

NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP  
DUAL ELIGIBLE BENEFICIARIES WORKGROUP

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TUESDAY  
APRIL 19, 2016

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The Workgroup met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Jennie Chin Hansen and Nancy Hanrahan, Co-Chairs, presiding.

PRESENT:

JENNIE CHIN HANSEN, RN, MS, FAAN, Co-Chair

NANCY HANRAHAN, PhD, PN, FAAN, Co-Chair

CHRISTINE AGUIAR, Association for Community  
Affiliated Health Plans

GEORGE ANDREWS, MD, MBA, CPE, Humana, Inc.

ELIZA BANGIT, JD, U.S. Department of Health &  
Human Services

GWENDOLEN BUHR, MD, MHS, Med, CMD, AMDA - The  
Society for Post-Acute and long-Term Care  
Medicine

MADY CHALK, MSW, PhD, Treatment Research  
Institute

JAMES DUNFORD, MD, City of San Diego EMS\*

ALINE HOLMES, DNP, MSN, RN, New Jersey Hospital  
Association

K. CHARLIE LAKIN, PhD, National Institute on  
Disability and Rehabilitation Research

ALICE LIND, BSN, MPH, National Association of  
Medicaid Directors

THOMAS LUTZOW, PhD, MBA, iCare

MICHAEL MONSON, Centene Corporation

KIMBERLY RASK, MD, PhD, Alliant Health Solutions

E. CLARKE ROSS, DPA, Consortium for Citizens  
with Disabilities  
GAIL STUART, PhD, RN, Medical University of  
South Carolina  
GREGG WARSHAW, MD, American Geriatrics Society  
JOAN LEVY ZLOTNIK, PhD, ACSW, National  
Association of Social Workers

NQF STAFF:

JANINE AMIRAULT, Project Analyst  
MEGAN DUEVEL ANDERSON, Project Manager  
SHEILA CRAWFORD, Administrative Manager  
ANN GREINER, Vice President, External Affairs  
MARGARET MCGINTY, JD, Senior Manager, Public  
Affairs  
DEBJANI MUKHERJEE, PhD, Senior Director  
ELISA MUNTHALI, MPH, Vice President, Quality  
Measurement  
ERIN O'ROURKE, Senior Director  
SARAH SAMPSEL, MPH, Senior Director\*  
MARCIA WILSON, PhD, MBA, Senior Vice President,  
Quality Measurement

ALSO PRESENT:

JENNIFER BARON, Centers for Medicare & Medicaid  
Services\*  
VENESA DAY, Centers for Medicare & Medicaid  
Services  
CAROLYN MILANOSWKI, Centers for Medicare &  
Medicaid Services\*  
PAUL PRECHT, Centers for Medicare & Medicaid  
Services\*

\* present by teleconference

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1 P-R-O-C-E-E-D-I-N-G-S

2 (9:03 a.m.)

3 CO-CHAIR HANRAHAN: Welcome, everyone.

4 My name is Nancy Hanrahan. I am a co-chair of  
5 the committee. I have been working with NQF for  
6 -- we will wait for a second.

7 MS. ANDERSON: So, while we are  
8 waiting for a few more technical assistants,  
9 operator, can you give the opening announcements  
10 to the people on the phone that we are going to  
11 start the meeting?

12 OPERATOR: Today's call will start  
13 momentarily.

14 CO-CHAIR HANSEN: Operator?

15 OPERATOR: Yes, ma'am, you may begin.

16 CO-CHAIR HANSEN: Thank you.

17 CO-CHAIR HANRAHAN: So, I think we are  
18 all set. Thank you. Thank you for being here.

19 It is just a delight for me to see  
20 people face-to-face. Phone calls are one thing  
21 and we do some work done but it is really, this  
22 is where it is going to happen. So, welcome,

1 everyone.

2 Jennie?

3 CO-CHAIR HANSEN: Yes, thank you. I  
4 am Jennie Chin Hansen. I am the co-chair with  
5 Nancy Hanrahan and I am delighted to see you all.

6 Just right off the bat, for how many  
7 of you is this first in-person face meeting?  
8 Okay, it looks like we have four of us in the  
9 room. And anybody else on the phone call for  
10 whom this is a first-time meeting?

11 So, we have the pleasure, as Nancy  
12 mentioned, to both see you as well as be with you  
13 during our once a year in-person meeting that we  
14 have. And as you can tell, the agenda is chock  
15 full and some of the preparatory work that many  
16 of you participated in is helping to, frankly,  
17 define some of the areas that we will go into.

18 And one of the things that strikes me,  
19 I am making a little bit of a commentary before  
20 we get into the content. I have had just the  
21 pleasure this past week of returning back from  
22 Scandinavia. And it was meeting of the

1 International Group for Quality and Safety in  
2 Healthcare. I happen to be on the Board on the  
3 Institute for Healthcare Improvement. So, this  
4 whole aspect of improving care is something that  
5 is obviously very core to the organization's  
6 sense of both safety and quality.

7 Something I was really struck about,  
8 and I think it brought me back to this meeting,  
9 is when there were 3,500 members who attended  
10 this international meeting and I could not put a  
11 little meter on the degree of enthusiasm people  
12 had for the idea of improving safety and  
13 improving quality of care.

14 And just looking and feeling that kind  
15 of enthusiasm and knowing kind of the intensity  
16 of what we are facing with the work that we are,  
17 along with the quality improvement work of the  
18 mission of NQF, the sense of how do we get to  
19 what is real important and something that we know  
20 will make a real difference in the lives of the  
21 beneficiaries and the consumers that we are a  
22 part of caring for.

1                   And so one of the things that we would  
2     like to do that is built into the agenda is  
3     toward the latter part of tomorrow afternoon is  
4     an opportunity for all of us to really think  
5     about what is the role that we might be playing.  
6     Those of us who come together for many years and  
7     those of you who are newly joining us, we all  
8     know that this was kind of a new constellation of  
9     work, having a population defined instead of  
10    saying a provider or an institution, or post-  
11    acute care is a very concrete way. What is it  
12    that we can do to make this valuable?

13                  I have joked -- I saw Alice Lind, who  
14    was the previous chair of this committee, that  
15    the whole question of what is this all about  
16    ultimately. And I think of three different  
17    areas: one is the whole aspect of  
18    accountability; and performance, performance that  
19    leads to payment; and then also improvement. And  
20    for those of you who were on the phone this last  
21    time we met, the Institute of Medicine has  
22    recently, I think within the past six weeks, come



1 out with the report on population health and what  
2 about measurement in population health. And I  
3 think it has some real germaneness to our work  
4 here.

5 So, as we do what we are charged to  
6 do, and that is operate under the aegis and the  
7 mission and purpose of the NQF and looking at the  
8 measures, endorsed measures, measures that people  
9 can use for both the Family of Measures and then  
10 what we call as the kind of the guiding Starter  
11 Set. And what about that big area that a lot of  
12 us, frankly, have been chomping at the bit for,  
13 whether for years or for those four of you who  
14 have joined us newly, what is going to make a  
15 difference for this population that is common in  
16 definition only by their economic status?

17 And so this is one of the areas that  
18 I think we have an opportunity to, after we go  
19 through the day and a half of work that we will  
20 be going through, to think about strategically  
21 what is the role in place and focus of this  
22 committee to continue to carry the ball so that

1 we do justice, frankly, to the populations that  
2 we are committed to making sure that quality is  
3 better, that measures are done well, that  
4 providers, as well as health systems themselves,  
5 can do this with the most effective targeting, so  
6 that we can get some results.

7 So, that is a preface. As I said, I  
8 was just so delighted to see the huge joyous  
9 energy that people had. And so I was thinking,  
10 how can we make that possible for measurement in  
11 quality here in the United States, in a way that  
12 we can do something similar by spending our time  
13 well, focusing on what is important, making it  
14 important from the eyes of the person who is  
15 receiving the care in partnership with providers.  
16 How can we make that kind of difference?

17 So, I just wanted to set that frame.  
18 And for some of the long-termers here, knowing  
19 that we have been trying to define an area and  
20 have a focus on topics that typically have not  
21 been within the purview of healthcare.

22 We have two guest speakers, tomorrow

1 later on. One of them is Alice Lind speaking  
2 about her experience and work now working on the  
3 state level in the State of Washington. We also  
4 have a Ph.D. social worker from Rush University  
5 who is going to be speaking to us on care  
6 coordination.

7 If you have had a chance to look at  
8 the slides in advance, there is one slide there  
9 that I think is very, very telling and it is a  
10 graphic to say that 20 percent of a person's  
11 health is based on clinical issues. Another 20  
12 percent is based on genetic aspects. But 60  
13 percent is this stuff that we normally don't  
14 measure. So, I think that is very important for  
15 us to kind of put as a context to why our work is  
16 so difficult. Because when we work with our  
17 Starter Set and available endorsed tools, they  
18 are actually about that 20 percent, while we are  
19 looking at the health of a person who is 100  
20 percent and many other factors that we don't do.

21 So, let us move along with this. And  
22 the three major themes that we have are first to

1 do our annual work to the Family of Measures and  
2 to review what I mentioned earlier about the  
3 Starter Set. And with that, what are the  
4 priority issues for dual eligibles relative to  
5 multiple chronic conditions? We will hear very  
6 soon from our representative from CMS because  
7 this whole focus of MCC, multiple chronic  
8 conditions, is now a major theme by CMS and by  
9 virtue of that, we will integrate that into our  
10 work.

11 And then tomorrow, in particular, we  
12 will look at the linkages to the community, as  
13 well as hearing from related NQF projects from  
14 some of the committees that a few of you are  
15 cross-linkages to.

16 So, I will now pass this on to Janine  
17 to do roll call.

18 MS. AMIRAULT: Hi, everyone. So, I am  
19 just going to conduct a quick roll call. So, if  
20 you could, just state that you are here when I  
21 call your name.

22 Jennie Chin Hansen.

1 CO-CHAIR HANSEN: Present.

2 MS. AMIRAULT: Nancy Hanrahan.

3 CO-CHAIR HANRAHAN: Here.

4 MS. AMIRAULT: Susan Reinhard.

5 (No audible response.)

6 MS. AMIRAULT: Just a note, we are not  
7 expecting Susan in person today.

8 Gregg Warshaw.

9 MEMBER WARSHAW: Here.

10 MS. AMIRAULT: Christine Aguiar.

11 (No audible response.)

12 MS. AMIRAULT: Michael Monson.

13 MEMBER MONSON: Here.

14 MS. AMIRAULT: Clarke Ross.

15 MEMBER ROSS: Here.

16 MS. AMIRAULT: Cheryl Irmiter.

17 (No audible response.)

18 MS. AMIRAULT: We also are not  
19 expecting her in person today.

20 Jette Hogenmiller.

21 (No audible response.)

22 MS. AMIRAULT: George Andrews.

1 MEMBER ANDREWS: Here.

2 MS. AMIRAULT: Thomas Lutzow.

3 MEMBER LUTZOW: Here.

4 MS. AMIRAULT: Alice Lind.

5 (No audible response.)

6 MS. AMIRAULT: Joan Zlotnik.

7 (No audible response.)

8 MS. AMIRAULT: Aline Holmes

9 MEMBER HOLMES: Here.

10 MS. AMIRAULT: Mady Chalk.

11 MEMBER CHALK: Here.

12 MS. AMIRAULT: James Dunford.

13 (No audible response.)

14 MS. AMIRAULT: Charlie Lakin.

15 MEMBER LAKIN: Here.

16 MS. AMIRAULT: Ruth Perry.

17 (No audible response.)

18 MS. AMIRAULT: Kimberly Rask.

19 MEMBER RASK: Here.

20 MS. AMIRAULT: Gail Stuart.

21 MEMBER STUART: Here.

22 MS. AMIRAULT: Aliza Bangit.

1 MEMBER BANGIT: Here.

2 MS. AMIRAULT: Venesa Day.

3 (No audible response.)

4 MS. AMIRAULT: And Deb Potter.

5 Deborah, are you on the phone?

6 (No audible response.)

7 MS. AMIRAULT: And Gwen.

8 (No audible response.)

9 MS. AMIRAULT: Just before we start,

10 I have a few notes. If you could please turn  
11 your cell phones to vibrate or silent. We  
12 understand that you have other obligations. So,  
13 feel free to use the space just outside, where  
14 you picked up your name tags if you need to make  
15 a phone call.

16 And for workgroup members on the  
17 phone, please simply ask it in the queue and we  
18 will let you know when it is your turn to speak.

19 You can use your tent cards here, to  
20 indicate that you would like to speak and we will  
21 let you know when it is your turn.

22 Please be sure to speak into the

1 microphones. It is just very important, as  
2 everyone on the phone will also be interested to  
3 hear what you have to say. And the staff also  
4 uses the recordings and transcripts to make sure  
5 that we accurately reflect the views in the room.

6 Public comments are spaced  
7 periodically throughout both days of the meeting.  
8 We invite commenters to share their thoughts  
9 during these commenting times personally by  
10 coming to the microphone or over the phone, by  
11 letting the operator know that you would like to  
12 make a comment.

13 We also encourage commenters to submit  
14 comments over the chat at any time throughout the  
15 day. We will directly share them with the  
16 workgroup and ensure that they are recorded.

17 Bathrooms are past the desk where you  
18 checked in, near the elevators. You just take a  
19 right down the hallway.

20 Breakfast and lunch are provided to  
21 our group members and participating NQF staff.

22 We will be using voting tools



1 throughout the day. Please participate in the  
2 practice round that we will do now. In this  
3 practice round we are just taking a poll of  
4 anyone interested in going to dinner tonight,  
5 6:30 at Georgia Brown's. And to vote, you just  
6 take your clicker here and you can see the voting  
7 screens are here on the sides. So, the polling  
8 is open. So, if we could just get a poll of  
9 anyone interested in dinner tonight. And just  
10 point it here at me. Thank you.

11 MEMBER BUHR: And the other thing I  
12 will say about the clickers. It is not like  
13 Chicago, where you vote early and often. When  
14 you vote once, no matter how many times you  
15 press, it is okay. And sometimes when we are  
16 looking to make sure we have all the votes, we  
17 may be one shy and Janine may say please vote  
18 again. It is okay, it is not double counting it.  
19 So, just one thing about the clickers.

20 MS. AMIRAULT: Just as one more  
21 reminder, organization and subject matter experts  
22 are asked to vote. Federal representatives are

1 encouraged to participate in all discussion but  
2 are requested to abstain from voting.

3 So, if you haven't voted for dinner  
4 tonight, just go ahead and point it at me. It  
5 looks like the clickers are working.

6 MS. ANDERSON: Thanks, Janine. This  
7 is Megan Duevel Anderson. I am so excited to see  
8 everyone here today. And for those of you on the  
9 phone, thank you very much for joining us.

10 For workgroup members on the phone,  
11 please do speak up if you would like to join the  
12 queue. And public, thank you very much in  
13 advance for your comments.

14 I would like specifically to give my  
15 appreciation to the co-chairs and the teammates,  
16 and everyone for joining us today. Sheila, who  
17 is supporting us, Janine, Debjani, and Marcia and  
18 Elisa who are in this room.

19 I am going to turn it over to Debjani  
20 to also welcome the group.

21 DR. MUKHERJEE: Hello, everybody. My  
22 name is Debjani. I am new to the Duals

1       Workgroup. And I am excited to be here. I have  
2       spoken to a lot of you and emailed a lot of you.  
3       So, it is nice to put a name to a face finally.

4               And at this point, I would also like  
5       to welcome our federal partners from the Centers  
6       for Medicare and Medicaid Services, Medicare and  
7       Medicaid Coordination Office, Venesa Day and  
8       Carolyn Milanowski.

9               And in the next section, our CMS  
10       colleagues will provide us with some thoughts and  
11       updates on the work around the duals population.  
12       We will also hear from Paul Precht about the CMS  
13       quality strategy and from Jennifer Baron about  
14       recent work with the financial demonstrations for  
15       duly eligible beneficiaries. And Venesa is here  
16       in person today. Welcome, Vanesa. And Carolyn,  
17       Paul, and Jennifer are on the phone.

18              MS. DAY: So, good morning. Thank you  
19       for having me. I just wanted to give some quick,  
20       very general opening things from CMS.

21              We really do appreciate the work that  
22       you have provided for us over the years. Every

1 year, we us what you give us kind of as our  
2 marching orders. And every year, we are reminded  
3 that there is more to do, more to be done,  
4 woefully stressed about what we need to get done  
5 and how we fit into all the moving pieces.

6 And I had some more elaborate remarks  
7 prepared but I just got here and sat down. I am  
8 not really ready. But I will say as I was  
9 driving here, I kind of thought about like how  
10 our work has changed and how our approach to the  
11 work has changed over the years. And so when we  
12 initially started this, we thought like oh, yes,  
13 we will just make everybody do what we want to  
14 get done. And so that didn't work, so we went  
15 back to the drawing board.

16 And then we said well, we will be kind  
17 of more collaborative, try to figure it out. And  
18 so that has worked more. But now we have added  
19 kind of ourselves as a hub and lots of tentacles.

20 And so as my colleagues start to talk  
21 through the different things happening in our  
22 office, I think the one thing we would like you

1 to keep in mind is that one, the work that we get  
2 from you guys in this process helps us to kind of  
3 filter in to other people's work and be smart  
4 about it, understanding where we need to be and  
5 what we need to touch and what works right for  
6 duals. And that has been a big part of our work,  
7 trying to get other folks to understand the  
8 importance of how our population impacts their  
9 work and also the measures that we want to see  
10 represented.

11 And we aren't as successful as we  
12 would like to see in a lot of ways but we  
13 definitely have made some progress.

14 When Carolyn talks, she is going to  
15 talk about a project that we have been working on  
16 for two years but really this last year is when  
17 we were able to get it to the finish line, where  
18 we were able to join with the Medicaid IAP, as  
19 well as Medicaid Home and Community-Based  
20 Services, LTSS components to put together a  
21 contract where we will do some measure  
22 development in areas that you guys have

1 highlighted for us as gaps. And that is some  
2 very important work that we are excited about  
3 over the next three years, trying to get more in-  
4 depth work from that.

5 But more immediately, we have produced  
6 or we will produce out of that contract two  
7 measures, behavioral health measures specified  
8 for duals and Carolyn, again, will give more  
9 detail about that work coming out of the  
10 measures. And we are really proud of that  
11 because it was really two years in the making.

12 And so now that is working, we are  
13 happy to have it done but that isn't all that we  
14 have done. When Jennifer talks, she will talk  
15 about our Managed Fee for Service Model and our  
16 Capitated Model. Really, we built our measure  
17 set on, for those two models, as you probably  
18 know, is from the work that you guys have  
19 provided. And we have changed those measure sets  
20 based on the work that you have provided and the  
21 information you have given us over the years.

22 And so thank you. We appreciate the

1 work and we have heard from you and we appreciate  
2 those calls and those emails and that direction  
3 that you have given us otherwise, in  
4 participating more broadly because we are really  
5 a small group and you ultimately are our way of  
6 being able to understand what really is happening  
7 and what direction we need to go in. So, thank  
8 you.

9 And I think I will turn it over to  
10 Carolyn.

11 MS. ANDERSON: Carolyn, are you on the  
12 phone?

13 MS. MILANOWSKI: Yes, I am. I think  
14 Jennifer Baron is going to go first because she  
15 is double booked today and would like to join her  
16 other meeting after she provides us her  
17 presentation.

18 MS. BARON: Thanks, Carolyn.

19 This is Jennifer. I am a senior  
20 advisor with the Medicare-Medicaid Coordination  
21 Office and I am actually based in Boston or I  
22 would have loved to have the chance to join you

1 in person today.

2 I just wanted to provide a really  
3 brief update on the status of the evaluation for  
4 the initiative under the Medicare-Medicaid  
5 Coordination Office, both forth the Financial  
6 Alignment Initiative and also briefly for the  
7 Initiative to Reduce Avoidable Hospitalizations  
8 among Nursing Facility Residents. And this will  
9 just be more of a process and status update than  
10 reviewing the result included in those reports.  
11 Though, certainly, if you have any questions  
12 about the results, please feel free to be in  
13 touch and I am happy to follow-up also together  
14 with the Innovation Center folks who directly  
15 oversee our evaluations.

16 When I talked with Debjani about this  
17 session, I said something like I am sure you guys  
18 aren't spending all of your free time reviewing  
19 these 200 plus page evaluation reports for our  
20 demonstrations. And she said you know, actually,  
21 they are. So, I knew this was a group I could  
22 get along with.



1                   And I understand you may also be  
2                   hearing more from Alice Lind later in the session  
3                   about some of the early Washington results as  
4                   well.

5                   But we have recently released three  
6                   evaluation reports publicly. Two were for the  
7                   state demonstrations under the Financial  
8                   Alignment Initiative and one was for the Nursing  
9                   Facility Initiative.

10                  The Nursing Facility Report was the  
11                  third annual report for that demonstration and  
12                  that initiative, just for anyone who might not be  
13                  familiar, CMS partners with organizations in  
14                  seven different states and they are implementing  
15                  clinical and educational interventions to reduce  
16                  hospitalizations and potentially avoidable  
17                  hospitalizations in nursing facility settings.  
18                  And that report covers the second performance  
19                  year for that initiative, which was 2014. We  
20                  released it in early February.

21                  And I guess I know I said I wasn't  
22                  going to focus on results but I will say now that

1 overall, the results were good. RTI is the  
2 evaluation contractor for that initiative and did  
3 find a more consistent pattern of positive  
4 effects in 2014 than in the previous year,  
5 although the results varied a little bit across  
6 the seven sites that are implementing the  
7 intervention.

8           The other two evaluation reports that  
9 we have released recently were in January and  
10 those were both for the state demonstrations  
11 under the Financial Alignment Initiative. The  
12 first of those reports is an issue brief and it  
13 provides an update on the status of  
14 implementation for the seven demonstration states  
15 that started by May first of 2014 and those were  
16 California, Illinois, Massachusetts, Minnesota,  
17 Ohio, Virginia, and Washington.

18           And the report includes mostly  
19 qualitative information. There is some  
20 enrollment data in there but the qualitative  
21 information came largely from in-person site  
22 visits that RTI conducted to each of those states

1 and also engaged in some follow-up with the  
2 states with other stakeholders and with CMS.

3 So, for those of you who have seen  
4 that report and may be following the demos under  
5 the Financial Alignment Initiative, you probably  
6 didn't see too many surprises in there. It talks  
7 about the successes of getting the initiatives  
8 off the ground, which was no small accomplishment  
9 in all of the prep and the stakeholder engagement  
10 that went into that. And it talks about the main  
11 challenges being the time and the resources  
12 needed to implement those demos and in  
13 particular, states. And to some extent, the  
14 plans that are participating in the Cap Model  
15 demos, getting up to speed on the Medicare  
16 requirements.

17 The second evaluation report for the  
18 Financial Alignment Initiative that we released  
19 in January was an issue brief summarizing the  
20 early, early results for the first performance  
21 period for the Washington Managed Fee For Service  
22 Model demonstration. And we note that we called

1       it an issue brief, rather than an actual report  
2       because there will be an annual report upcoming  
3       that we are planning to release this year,  
4       actually, that will have a lot more detail and  
5       include additional qualitative and quantitative  
6       information and further discussion of the data  
7       and what the results actually mean.

8               So, the issue brief that we released  
9       included some enrollment information, some  
10       information on what the demonstration eligible  
11       population looked like, demographics, focus group  
12       results which were actually really good, some  
13       early descriptive results on utilization measure  
14       and preliminary Medicare savings results.

15              And so as I mentioned, overall, those  
16       results generally look good, although for the  
17       utilization data, in particular, I would just  
18       point out that the comparison group data were not  
19       included in that issue brief. They will be in  
20       the annual report.

21              So, while the descriptive data  
22       indicates some encouraging trends in the demo

1 group, it is also possible that the comparison  
2 group trends could be different or could be  
3 better.

4 So, in terms of next steps for the  
5 evaluation, for the Nursing Facility Initiative,  
6 we expect the next annual report to be posted on  
7 roughly the same schedule as this one was. So,  
8 that would be early 2017. And you also may have  
9 heard that we recently announced a second phase  
10 of that initiative that adds a payment reform  
11 piece to the clinical and educational  
12 interventions that are currently underway under  
13 Phase I of the initiative. And so we will be  
14 procuring an evaluation contractor for that  
15 second phase of the Nursing Facility Initiative  
16 as well.

17 And then for the Financial Alignment  
18 Initiative, we are really excited to be able to  
19 release the first annual reports for some of  
20 those demonstrations this year and those will be  
21 for the state demonstrations that started in  
22 2013. So, those are Washington, Massachusetts,

1 and Minnesota. And RTI, who is the evaluation  
2 contractor there, is also beginning work on the  
3 annual reports and their related evaluation and  
4 measurement activities for the demos that started  
5 the following year, so in 2014. And we will  
6 expect to start releasing the reports for the  
7 2014 states next year and that will likely be on  
8 a staggered basis, just because there are a  
9 number of those.

10 And we will be making all of those  
11 reports public. The three reports that I just  
12 mentioned are posted on the MMCO website. I  
13 would be happy to share the link. If you need  
14 any help finding it, please let us know. And I  
15 am also happy to take any questions now, if there  
16 is time but please don't hesitate to reach out if  
17 you have any questions after the session.

18 CO-CHAIR HANSEN: Thank you very much.

19 Do any of the committee members have  
20 any questions for our CMS colleague?

21 Okay, if not, I will turn this back  
22 over to Venesa to acknowledge the next speaker.

1 MS. DAY: Sure. Carolyn?

2 MS. MILANOWSKI: Yes, I am here.

3 Hello. This is Carolyn Milanowski.

4 I work on the Colleague Team in the Medicare-  
5 Medicaid Coordination Office under Venesa's  
6 leadership. I am glad to hear Bernie Sanders is  
7 in the audience, right from the Vatican to the  
8 MAP Duals Workgroup. Was that him on the call  
9 that I heard?

10 I wanted to provide an update, as  
11 Venesa said, on the CMS measure development  
12 contract that we are currently working on. So, as  
13 you probably know, the Medicare-Medicaid  
14 Coordination Office and the Center for Medicaid  
15 and CHIP Services have collaborating on a measure  
16 development contract to fill measurement gaps for  
17 Medicare and Medicaid enrollees and adult  
18 Medicaid enrollees. It has kind of a long name.  
19 It is called the Quality Measure Development and  
20 Maintenance for CMS programs serving Medicare and  
21 Medicaid enrollees and Medicaid-only enrollees.

22 CMS announced the project when it was

1 awarded to Mathematica in the fall of 2015. It  
2 is a three-year contract and for MMCO, the  
3 contract requires the development of six measures  
4 that are specific to the dual population, as  
5 Venesa said, two in each year of the contract.  
6 And for the Medicaid Innovation Accelerator  
7 Program, it requires 12 measures to be developed,  
8 four in each year of the contract.

9 And then separately, the contractor is  
10 also required to complete testing of 13 MLTSS  
11 measures for CMCS, which have been developed  
12 under another contract. So, this seemed to be  
13 sort of a natural fit in this contract. And  
14 those include measures such as an assessment  
15 composite, shared care plan, and functional  
16 status assessment, to name a few, all of which we  
17 think are relevant to duals and just sort of seem  
18 to fit under the contract.

19 So, I'm sure you are aware of the  
20 priority areas of development under the IAP  
21 program, substance use disorders, physical mental  
22 health integration, beneficiaries with complex



1 needs or sometimes called super utilizers and  
2 community integration/LTSS.

3 Of course, these areas are critical  
4 for duals as well. So, it makes sense to merge  
5 all of this work under one contract and even for  
6 measures to be developed that are common to both  
7 populations or even could be specified for both.  
8 So, we expect that almost all of the measures  
9 being developed or tested in this project will  
10 directly or indirectly benefit the duals  
11 population.

12 So, by the end of the contract, at  
13 least for MMCO, we should have at least six  
14 measures and likely more tailored specifically to  
15 the needs of duals and then we will have this  
16 larger set of measures that could be specified  
17 for duals in the future or can otherwise benefit  
18 duals, and certain types care.

19 So, for the dual measures, I just want  
20 all of you to know that the statement of work  
21 relied heavily on the recommendations of this  
22 workgroup and I have verbally shared your

1 insights with the contractor as well, not by  
2 individual name but as a group.

3 We emphasized the need for measures  
4 specifically designed for duals, for the needs of  
5 duals, given their complexity of healthcare needs  
6 and their multiple social stressors, and you know  
7 measures that matter to duals and their families  
8 and enhance their quality of life.

9 We highlighted the need for more  
10 outcome measures and person-reported outcomes.  
11 We also emphasized the domains of person- and  
12 family-centered care and care coordination, among  
13 others. But we also wanted to allow the contract  
14 and the TEPs enough latitude to make the  
15 recommendations based on their analysis of the  
16 environmental scans that were done and the  
17 literature review and the current state of the  
18 scientific evidence for individual concepts and,  
19 of course, the criteria of importance,  
20 feasibility, and usability.

21 So, the major milestones to date that  
22 you may be interested in are that first, there

1 were multiple environmental scans that were  
2 completed, I think all of them by the end of  
3 January. Two TEPs were recruited and formed  
4 under this contract. One, to advise on  
5 developing measures for the duals, the IAP  
6 priority area of community integration, LTSS, and  
7 the testing for the MLTSS measures. So, these  
8 three areas seem to be a good fit and had lots in  
9 common, given the large population of duals and  
10 LTSS.

11 The other test is for substance use  
12 disorders, physical and mental health integration  
13 and beneficiaries of complex needs. The duals  
14 LTSS TEP members met on April 13 for the first  
15 time to consider the candidate measure concepts.  
16 And then the IAP, what we call the IPA TEP is  
17 meeting this week.

18 So, the dual TEP is still in the  
19 process of completing a post-TEP survey and the  
20 results will be somewhere in the report to CMS  
21 due in early May. And then the IAP TEP report  
22 should arrive shortly thereafter.

1           And then from there, MMCO will closely  
2       coordinate the measure selection process with  
3       CMCS and other CMS components and you know assess  
4       how all of the measures will fit into our overall  
5       quality improvement strategies. We also plan to  
6       consult with ACL on their HCBS measure  
7       development contracts with University of  
8       Minnesota on HCBS outcome measures.

9           So, from there, we will post the  
10      measure information forms of the candidate  
11      measures to the CMS website for public comment  
12      and I can certainly give a heads up to the NQF  
13      staff when the public comment period is open, in  
14      order to pass on to you.

15           Once the measures are selected, the  
16      contractor will begin development two measures  
17      for duals, as we said, and four under the IAP  
18      program in the base year. And testing of the  
19      base year measures is scheduled to begin in late  
20      July, early August. So, we are on track  
21      currently. Hopefully, we will stay on track.

22           For the MLTSS measures, alpha testing

1 has begun with 11 planned and should wrap up this  
2 month.

3 And then each TEP will be convened  
4 again in September to consider measure concepts  
5 for the second and third years of the contract.

6 So, I just wanted to end by expressing  
7 CMS's great appreciation for your hard work, your  
8 insights and your guidance on the overall system  
9 transformation for duals. We cannot thank you  
10 enough for your contribution to this work.

11 Thank you also to the NQF staff for  
12 your incredible stewardship of this project for  
13 the past three years. You have all provided the  
14 foundation for much of our quality strategy for  
15 duals. And I know you know how important this  
16 work is to so many people.

17 So, we're as anxious as you all are to  
18 start implementing these measures that we are  
19 hoping to make a difference for duals and their  
20 families and caregivers.

21 So, I can open up now for questions or  
22 do we want to save questions for the end,

1 Debjani?

2 DR. MUKHERJEE: Why don't have Paul  
3 present and then we can take questions for  
4 everybody at the end?

5 MS. MILANOWSKI: Okay, sure. Thank  
6 you.

7 MR. PRECHT: Hi, this is Paul Precht.  
8 I am in the front office of the Medicare-Medicaid  
9 Coordination Office. My focus is a little bit  
10 narrower than either Venesa's or Carolyn in that  
11 I am working specifically on our quality ratings  
12 strategy for the Medicare-Medicaid plan. So,  
13 really, you know among the measures that you all  
14 work on, my focus is on measures applicable to  
15 capitated plans that deliver the full array of  
16 Medicare Part D and Medicaid services, including  
17 behavioral health and long-term services and  
18 supports.

19 Last November, we released a very high  
20 level roadmap to getting to a place where we  
21 could have star ratings for the MMPs that are  
22 analogous to the star ratings that exist now in

1 the MA and Part D program that would be consumer  
2 friendly to allow consumers to see, both on an  
3 overall basis as well as you know underneath that  
4 how the MMPs are doing compared to their other  
5 enrollment choices. And that could also be  
6 robust enough to serve potentially as a basis for  
7 adjusting payment.

8 Now, I want to caution here that we  
9 are not talking about layering anything on the  
10 existing payment system that exists now under the  
11 demonstration in which there are quality  
12 withholds. This is sort of to get us ready in  
13 the event that a model test is successful and it  
14 becomes a permanent part of the program and we  
15 walked through notice and comment regulation,  
16 putting out proposed rules to develop payment  
17 adjustments based on quality measures.

18 So, the question, the roadmap  
19 basically says we are looking and building on the  
20 existing MA and Part D rating that exists now  
21 that cover those services but a lot of what MMPs  
22 deliver, there aren't good measures. So, in

1 particular, LTSS, behavioral health, substance  
2 use disorder. So, we are relying very heavily on  
3 the work that Carolyn described in terms of  
4 measure development. For new measures that would  
5 be applicable to capitated plans that deliver  
6 those services but also looking at the exiting MA  
7 and Part D measures to make sure that those are  
8 specified in a way that are appropriate to duals,  
9 that they don't exclude cohorts of folks who are  
10 more prevalent in the dual eligible population  
11 but it might be appropriate to exclude when you  
12 are talking about sort of MA plans that focus  
13 more broadly on the Medicare population.

14 As we do this work, we have to have an  
15 eye towards what is practical to implement, in  
16 terms of reporting burden for plan, in terms of  
17 how it impacts their care processes for  
18 providers. So, I will just mention two aspects  
19 of that. One is we are very interested in how  
20 the Medicare-Medicaid enrollees, how they  
21 perceive the care that they get, the quality of  
22 life that they have as a result of the full array



1 of services, including the community support that  
2 they receive through those MMPs. And so to get  
3 that, you have to ask the beneficiaries their  
4 views. And so one way that that happens is  
5 through survey instruments. So, there exists  
6 now, as you well know, the CAHPS Surveys, the  
7 Health Outcome Surveys. There are additional  
8 surveys used in the HCBS population. There is  
9 also a lot of concern about overloading  
10 populations with surveys about the appropriate  
11 sampling when maybe only a segment of the plan  
12 population is receiving certain services like  
13 LTSS. So, that is something that we have to keep  
14 in mind as we work on measure development to make  
15 sure that the end result are measures that are  
16 not only good but that can practically be  
17 measured by the plan. The other aspect of that  
18 is the use of assessment tools or patient-  
19 reported outcomes, thinking about the value that  
20 they have both for measurement but also for  
21 informing how care is delivered but also being  
22 cautious about implementing anything that from on

1 high at the provider level affects how care is  
2 delivered, how the conversation between  
3 beneficiaries and their providers are conducted.

4 So, that all goes into the mix. It is  
5 a little, I am sure for stakeholders out there,  
6 this process may be a little frustrating because,  
7 as I said we released a sort of high-level  
8 roadmap in November but we are years away from  
9 implementing a rating system.

10 So, in the interim, we want to  
11 continue the dialogue and we also want to move  
12 step-wise to the extent we can in the direction  
13 of a rating system. And so the next thing that  
14 we expect to do is to release data on plan  
15 performance, on the measures they currently  
16 report on the Medicare Advantage and Part D  
17 world, as well as measures reported across all  
18 MMPs that cover additional areas not covered by  
19 the measures of the MA and Part D ratings and  
20 that with each successive year, the hope is to  
21 get that array more robust, both in terms of the  
22 measures reported but also in terms of how the

1 methodology that is used for comparison.

2 At its outset, it will not be as  
3 consumer friendly as a star rating but that is  
4 also part of the work that we will be doing over  
5 the succeeding years to improve it. And I think  
6 in the interim, it provides consumers with some  
7 information not now available, as well as other  
8 stakeholders to assess how the MMPs are doing on  
9 a host of measures.

10 So, I will leave it there in the hopes  
11 of providing some time for questions for myself  
12 or Carolyn or Venesa.

13 CO-CHAIR HANSEN: Thank you very much  
14 for those of you who have shared the information  
15 that each of you are working on in the sense of  
16 process and time frame.

17 We do have some questions here and I  
18 think that we could take probably two or three  
19 questions at most and then what we will do is  
20 have a chance to incorporate what you have  
21 brought to us in some of our slides that are  
22 coming up here.

1                   So, I would like to call on Clarke  
2                   Ross first and then Tom, second.

3                   MEMBER ROSS: Hi, Carolyn. I have two  
4                   questions for you. Clarke Ross with the  
5                   Consortium for Citizens for Disabilities. The  
6                   first question is who will be doing the testing  
7                   of these new measures.

8                   MS. MILANOWSKI: So, it depends on the  
9                   measures that are chosen. I am sorry to not be  
10                  able to give a precise response. But you know it  
11                  will depend on the level of setting but we do  
12                  expect at least some will be for plans. So, we  
13                  will have plans to participate in the testing.  
14                  So, yes, I'm sorry I can't say much more at this  
15                  point.

16                  MEMBER ROSS: Okay, the second  
17                  question is Charlie Lakin and I continue to  
18                  identify measures that are used by multiple  
19                  states, for example, the National Core Indicators  
20                  of the Personal Outcome Measures that have been  
21                  used for almost 30 years. And I know they are in  
22                  your environmental scan but did you incorporate

1       some of the core concepts of their measures into  
2       your testable measures?

3               MS. MILANOWSKI: All I can say at this  
4       point is we did incorporate those concepts in our  
5       statement of work. We have discussed those  
6       surveys and those are being considered but that  
7       is all I can say on those at this point.

8               MEMBER ROSS: Thank you.

9               CO-CHAIR HANSEN: Tom.

10              MEMBER LUTZOW: Yes, Tom Lutzow with  
11       iCare in Milwaukee.

12              You know we often question what is CMS  
13       thinking and, if you don't mind, I would like to  
14       ask you a forensic question along those lines.

15              It strikes me that to do what Paul  
16       wants to do in terms of reimbursing based on  
17       measures, the secret there is differentiation,  
18       separating good providers from bad providers,  
19       good plans from bad plans, and so on. But that  
20       differentiation doesn't necessarily support  
21       population health impact. And I am struck by the  
22       fact that the IMPACT Act has gotten everybody

1 organized around readmission prevention and I  
2 don't suspect that readmission prevention as a  
3 measure is going to be a good differentiator, in  
4 terms of quality necessarily but that is not its  
5 intent. It is to get population impact.

6 And so isn't there a need for more  
7 measures like that that organize resources, not  
8 expecting that if everybody gets good at it we  
9 are all of a sudden going to move it to the  
10 display measures status but we want to keep it in  
11 a star performance status across all providers.  
12 And diabetes is one of those population health  
13 issues that can't be impacted in piecemeal  
14 fashion. It has got to be attacked in an  
15 organized fashion, much like the way readmission  
16 prevention is being attacked.

17 So, is there tension within CMS itself  
18 in achieving population impact and then  
19 reimbursement differentiation at the same time?  
20 What is that? Does it exist and what is its  
21 magnitude?

22 MS. DAY: So, can you help me

1 understand like where you are going with you  
2 question? Because I am not sure I am clear on --

3 MEMBER LUTZOW: Well, I want to submit  
4 that we really won't put a dent in diabetes  
5 control by making only one sector of the  
6 healthcare system like plans or pick another one  
7 and expect to get anywhere with one sector having  
8 responsibility for it. All sectors have to be.  
9 And by that I mean hospitals, physicians, nursing  
10 homes, home health agencies, health insurance  
11 plans. Everyone has to be on that page. And  
12 hopefully, we will get good at it and hopefully  
13 we won't have a measure that ends up going to the  
14 display page because we can't let up on it.

15 So, I think we have something, a model  
16 with readmission prevention that actually does  
17 organize all systems toward the same end but  
18 there is relatively few of those.

19 MS. DAY: So, I think yes, I agree.  
20 We often talk about how I want to say the success  
21 of the work around readmissions. And you are  
22 right, it is kind of like all systems go.

1       Everybody is paying attention to it. We are  
2       measuring it in as many ways as we can and making  
3       sure we have it on the right levels in assessing  
4       who is touching it.

5               I think I also agree that it would  
6       make sense to try that type of approach in other  
7       areas that are important for population health.

8               I don't think I can speak to the  
9       broader CMS effort around something as specific  
10      as hypertension but I think the awareness is  
11      there, that the type of effort put behind  
12      readmissions is working.

13              MR. PRECHT: I would also add that I  
14      think in the measure development work there is  
15      attention given to trying to make the measures  
16      consistent and harmonious across different plan  
17      types and across different sort of levels on  
18      plans to the providers so that we are -- you know  
19      when we are getting all hands on deck to address  
20      these big issues like diabetes care or  
21      readmissions, we are not burdening providers with  
22      conflicting and duplicative reporting



1 requirements that get in the way of providing  
2 care.

3 But I think your point is well taken  
4 that on the areas that are sort of at the core of  
5 where we want to go with healthcare in terms of  
6 the major chronic conditions like diabetes or the  
7 problems that we have identified in readmissions  
8 or avoidable hospitalizations that they have a  
9 value in organizing and incentivizing the  
10 delivery of care that exists, I think that even  
11 if we come to a place where everybody is sort of  
12 topping out, which would be great.

13 So, that point is well taken and I  
14 appreciate you raising that.

15 CO-CHAIR HANSEN: Thank you. I know  
16 that there is probably far more discussion. I  
17 want to honor Nancy Hanrahan's last question  
18 before we move on.

19 CO-CHAIR HANRAHAN: So, thank you for  
20 the updates on what CMS is doing. It sounds like  
21 a lot of work and a lot of really good work. My  
22 question has to do with the data that you are

1 going to be collecting for each of these measures  
2 that you are developing. Is that data going to  
3 be available to anyone else outside of Medicare,  
4 Medicaid, or CMS for research purposes or even  
5 for purposes of doing population health studies?  
6 Because the big effort at this point, in my  
7 estimation, is doing a Watson-like population  
8 review so you can identify patterns at the  
9 population level and link multiple data sources  
10 in order to really get the full scope which is  
11 really, in my estimation, the biggest challenge  
12 for dual eligibles. Because as Jennie says, 60  
13 percent of what we are dealing with has to do  
14 with very difficult measures.

15 And so I am interested in hearing what  
16 the plan is for really getting some external CMS  
17 help with this kind of data to really move this  
18 along.

19 MS. DAY: So, Carolyn, do you want to?

20 MS. MILANOWSKI: Sure, all of these  
21 measures will be available to the public. We  
22 will be reporting on them at various steps.

1                   So, first, we will provide for public  
2                   comment the measure information forms and the  
3                   measure justification forms. And then, once the  
4                   measure testing has begun, we will provide the  
5                   measure testing reports. And then yes,  
6                   ultimately, these will be available -- the data  
7                   will be available to the public.

8                   CO-CHAIR HANSEN: Thank you. I think  
9                   we have one more question because we --

10                  MEMBER MONSON: This is a question for  
11                  Carolyn. So, how are you all thinking about on  
12                  the MLTSS measures about taking advantage or are  
13                  you thinking about taking advantage of the data  
14                  that is being collected and the comprehensive  
15                  needs assessments that are being done either in  
16                  the fee for service system, by the case  
17                  management organizations or in the MLTSS world by  
18                  the health plans for those measures that the data  
19                  doesn't exist in claims or the self-report from a  
20                  CAHPS Study isn't necessarily going to capture  
21                  the richness. I am just curious about how you  
22                  are thinking about tapping into that data source.

1 MS. MILANOWSKI: Yes, good question.  
2 I don't think we know yet. We are not entirely  
3 sure how the testing will work out for that  
4 particular measure and then if and how we will  
5 use that measure. So, I'm sorry, I don't have  
6 much expertise in that area. I don't think we  
7 have anyone from CMCS on the line. It will start  
8 with them and we will see how it might be  
9 applicable to duals but I just don't know that  
10 yet.

11 CO-CHAIR HANSEN: Well, thank you to  
12 our CMS colleagues for giving us a glimpse of  
13 different bodies of work. I think what we have  
14 heard are some concerns to make sure that they  
15 have some alignment on a key level. One is to  
16 existing databases to conditions so that is not  
17 one-off and the ability for us to use available  
18 but disjointed collect data that currently exists  
19 to think about this.

20 So, we appreciate very much so Venesa,  
21 having you and your team be able to give us some  
22 glimpses and some heads up for us relative to

1 things that we might have to think about as a way  
2 of pointing out elements that we may have some  
3 concern.

4 So, thank you very much to our CMS  
5 colleagues here.

6 Our next thing is, since everybody  
7 seems to be here who is going to be physically  
8 here, I know we didn't do this at the very  
9 beginning and we are going to turn this next over  
10 to Debjani to talk about where we have been in  
11 the past five years.

12 As you are speaking, at this moment,  
13 could you just go quickly around to say your name  
14 and just the organization or the specialty that  
15 you happen to represent, so as we hear you speak,  
16 perhaps people could have that in context?

17 MEMBER AGUIAR: Sure. So, I'm  
18 Christine Aguiar. I am with Association for  
19 Community Affiliated Plans, also known as ACAP.  
20 And so I represent the Medicare and Managed Long-  
21 Term Care Plan. So, we have D-SNPs, the majority  
22 of which are integrated, then Medicare-Medicaid

1 plans.

2 And our plans constitute, depending on  
3 the month, between 25 percent to 30 percent of  
4 enrollment in the Financial Alignment  
5 Demonstration.

6 CO-CHAIR HANSEN: Thank you.

7 MEMBER HOLMES: I'm Aline Holmes. I'm  
8 Senior Vice President for Clinical Affairs for  
9 the New Jersey Hospital Association here as a  
10 representative of the American Hospital  
11 Association. Thank you.

12 MEMBER WARSHAW: Hi, my name is Gregg  
13 Warshaw. I am --

14 MS. ANDERSON: Gregg, your mic is not  
15 on.

16 CO-CHAIR HANSEN: Please make sure  
17 your mics are on when you introduce yourselves.  
18 Thank you.

19 MEMBER BANGIT: Hi, I'm Eliza Bangit.  
20 I'm with Administration for Community Living at  
21 the Department of Health and Human Services. I  
22 am also the government task lead to the HCBS,

1 NQF's HCBS task order and also the quality lead  
2 at the Administration for Community Living.

3 MEMBER LAKIN: Hi, I'm Charlie Lakin.  
4 I am twice retired, once as Director of the  
5 Research and Training Center on Community Living  
6 at the University of Minnesota and once as  
7 Director of the National Institute on Disability  
8 and Rehabilitation Research.

9 MEMBER ROSS: Hi, I'm Clarke Ross. I  
10 work for the American Association on Health and  
11 Disability but I am here representing the  
12 Consortium for Citizens with Disabilities, which  
13 is 113 national disability organization focused  
14 on public policy work here in D.C. founded in  
15 1973.

16 MEMBER CHALK: I'm Mady Chalk. I'm  
17 Senior Policy Advisor to the Treatment Research  
18 Institute and working actually with CMS on the  
19 IAP measures.

20 MS. CRAWFORD: Good morning. My name  
21 is Sheila Crawford. I'm the Administrative  
22 Manager for our Quality Measurement Department

1 and I am here to assist the Duals Team with their  
2 meeting this morning.

3 MS. AMIRAULT: Hi, again. I'm Janine  
4 Amirault and I am the Project Analyst on the  
5 Duals Project.

6 MS. ANDERSON: Megan Duevel Anderson  
7 Project Manager for the Dual Beneficiary  
8 Workgroup. I am also going to see whether or not  
9 we have any workgroup members on the phone.

10 Not at this time.

11 CO-CHAIR HANSEN: Hi, I'm Jennie Chin  
12 Hansen and was the recent Chief Executive for the  
13 American Geriatric Society but my primary  
14 connection probably to this work is I was about  
15 25 years with the original PACE Program in San  
16 Francisco called the On Lok.

17 CO-CHAIR HANRAHAN: Hi, everybody.  
18 Nancy Hanrahan. Currently, I'm the Dean of the  
19 School of Nursing at Northeastern University but  
20 my interest in my tenure here has been about five  
21 years working in these groups and seeing a lot of  
22 faces that I have seen for a long time.



1                   But I have done mental health services  
2                   research at the University of Pennsylvania for a  
3                   number of years with a focus on people with  
4                   serious mental illness, which are often the dual  
5                   eligible groups. So, I feel like I also bring  
6                   here my mother has Alzheimer's and I'm a  
7                   consumer. So, I have am very strongly invested  
8                   in how we manage these kinds of really  
9                   complicated measures to ensure that we have a  
10                  major transformation in our system.

11                 DR. MUKHERJEE: Hi, my name is Debjani  
12                 Mukherjee and I am the Senior Director for this  
13                 Dual Eligible Beneficiaries Workgroup.

14                 MS. GREINER: Good morning. My name  
15                 is Ann Greiner. I am Vice President of Public  
16                 Affairs here at the National Quality Forum.

17                 MS. MCGINTY: Good morning. Meg  
18                 McGinty, Senior Manager for Public Affairs here  
19                 at NQF.

20                 MEMBER MONSON: Hi, I'm Michael  
21                 Monson. I have national product responsibility  
22                 at Centene for our LTSS products, as well as our

1 financial alignment demonstrations. And we have  
2 LTSS products in seven states and MMPs in six  
3 states and are the largest LTSS plan and the  
4 second largest MMP. I'm thrilled to be here.

5 MEMBER BUHR: Hi, my name is Gwen  
6 Buhr. I am a geriatrician at Duke University and  
7 I am representing AMDA, The Society for Post-  
8 Acute and Long-Term Care Medicine.

9 MEMBER ANDREWS: Good morning. I'm  
10 George Andrews. I am a cardiologist and I serve  
11 as Humana's Corporate Chief of Quality.

12 MEMBER LIND: Alice Lind, Washington  
13 State Medicaid and I am here representing the  
14 National Association of Medicaid Directors.

15 MEMBER RASK: Kimberly Rask, I'm a  
16 general internist at Alliant Health Solutions.

17 MS. ANDERSON: Kimberly, you don't  
18 have to hold it down. Let's get the red light to  
19 come on.

20 MEMBER RASK: I'm not very technically  
21 savvy. Anyway, so I am the QIN-QIO for  
22 Georgia/North Carolina. We have two ESRD

1 networks and we also do Medicaid management work  
2 across the southeast.

3 MEMBER ZLOTNIK: Joan Levy Zlotnik.

4 I am representing the National Association of  
5 Social Workers, where I am a Senior Consultant to  
6 NASW. And I guess I have been on the committee  
7 since the beginning.

8 MEMBER LUTZOW: Tom Lutzow. I am  
9 President of iCare. iCare is an original  
10 research and demonstration project funded by  
11 HCFA, now CMS, for testing the value of managed  
12 care for SSI individuals.

13 We have the distinct honor, I guess,  
14 of being the only plan in the country that was  
15 moved from a three and a half-star measure to a  
16 four-star measure by virtue of the scoring  
17 changes in the call letter, regardless of which  
18 method was used, categorical, index, or indirect  
19 standardization. And it turns out they picked  
20 categorical index.

21 So, we benefited from the fact that  
22 iCare serves duals, 70 percent of which are

1 disabled duals.

2 MEMBER STUART: Hi. I'm Gail Stuart.  
3 I'm the Dean of College of Nursing and a  
4 Professor in the Department of Psychiatry at the  
5 Medical University of South Carolina in  
6 Charleston.

7 Long experience in clinical research  
8 activities in relationship to behavioral health.  
9 And apparently, and actually for the last eight  
10 years, serves as President of the Annapolis  
11 Coalition on the Behavioral Health Workforce.

12 MS. DAY: Good morning. My name is  
13 Venesa Day and I am currently working at CMS with  
14 the Medicare and Medicaid Coordination Office. I  
15 am the lead for the quality work with that group.

16 CO-CHAIR HANSEN: Thank you very much.  
17 And Marcia, we are doing just a quick  
18 introduction of everybody around the table.

19 DR. WILSON: Quickly, Marcia Wilson.  
20 I am the Senior Vice President here at NQF for  
21 Quality Measurement. Thank you.

22 CO-CHAIR HANSEN: Well, thank you all.

1 It just gives us a sense of who is around the  
2 table. Sorry.

3 MS. MUNTHALI: Elisa Munthali, Vice  
4 President for Quality Measurement.

5 CO-CHAIR HANSEN: Thank you, Elisa.

6 So, let me turn this over to Debjani,  
7 who is going to have a chance to talk about where  
8 we have been in five years and the what is ahead.

9 DR. MUKHERJEE: Thank you. So, in the  
10 next set of slides what I am going to do is look  
11 at MAP at five years. And the goal to do this is  
12 to take a quick look at the achievements over the  
13 past five years before sort of move forward and  
14 discuss future directions.

15 So, in pursuit of the National Quality  
16 Strategy, MAP provides input to HHS on the use of  
17 performance measures to one, achieve the goals of  
18 improvement, transparency, and value; identify  
19 gaps in measure development testing, and  
20 endorsement; encourage measure alignment across  
21 public and private programs, settings, levels of  
22 analysis, and populations.

1           So, over the past five years, MAP has  
2       made significant strides in strengthening the use  
3       of measures within federal programs. And just to  
4       give you some statistics, there are over 1,543  
5       measures that have been submitted for  
6       consideration by MAP for use in over 20 federal  
7       programs. And 50 percent of them have been  
8       process measures and about a third have been  
9       outcome measures.

10           However, guidance from MAP over the  
11       five years has promoted a change in the type of  
12       measures submitted for consideration. And in  
13       2015, for the first time in MAP's history, more  
14       outcome measures were submitted for consideration  
15       than process measures.

16           And HHS has increasingly looked to MAP  
17       to provide up-front guidance prior to investments  
18       in measure testing as well. And we see more  
19       measures come through that are in development.

20           And in 2015, more than 60 percent of  
21       the measures submitted for consideration were  
22       under development and not fully tested. And less

1       than 30 percent of measures submitted were NQF-  
2       endorsed, due to their stage of development.

3               The next is a quick diagram that shows  
4       the change in the type of measures coming through  
5       over time. So, you can see there is a greater  
6       focus on transition of care, engaging patients in  
7       decisionmaking, as well as making care safer  
8       between 2011 and 2015.

9               So, in addition to changes in the  
10      performance measures that MAP has evaluated in  
11      the past five years, there have also been  
12      strategic shifts in the nature of quality  
13      initiative programs. As we all know, MAP was  
14      created by ACA, a landmark legislation that  
15      dramatically altered the healthcare landscape and  
16      ushered in an era of value-based purchasing.

17              And MAP has an important in  
18      considering measures for these new initiatives.  
19      HHS has continued to show its commitment to  
20      value-based purchasing best illustrated by the  
21      January 2015 announcement that it has set a goal  
22      of time: 90 percent of all traditional Medicare

1 payments to quality or value by 2018 through its  
2 quality initiative programs.

3 The landscape for federal quality  
4 initiatives has been continually evolving. And a  
5 good example is the Medicare Access and CHIP  
6 Reauthorization Act (MACRA) legislation. It  
7 repealed the Sustainable Growth Rate, tied  
8 payment to value versus the old system of volume,  
9 consolidated value-based payment modifier,  
10 physician compare, physician quality reporting  
11 system, Medicare and Medicaid electronic health  
12 record initiative into the Merit-based Incentive  
13 Payment System, the MIPS.

14 And what the MIPS will do, going  
15 forward, is evaluate how payments are distributed  
16 to providers based on the quality of care  
17 provided, resource use, meaningful use of EHR  
18 technology and clinical practice improvement.

19 Another such legislation is the IMPACT  
20 Act. And for time sake, I think we all know what  
21 the IMPACT Act is. We will move on to the next  
22 slide. That's fine.



1                   And this is another schematic graph to  
2 show, over time, pay per reporting is going down  
3 and pay for performance and payment measures  
4 around measurement and quality are going up.

5                   So, the next slide talks about the MAP  
6 and CDP alignment. MAP initially depended on the  
7 NQF CDP, the consensus development process to  
8 endorse measures and to evaluate testing and  
9 robustness of evidence before it came to MAP for  
10 consideration.

11                  Over time, what happened is there is  
12 an interdependency between MAP and CDP which  
13 requires a seamless flow of information between  
14 the two process. Insight gained from MAP on  
15 pipeline measures are fed into the CDP process  
16 but as MAP sees more measures under development,  
17 this seamless flow of information is more  
18 important, so that any measure that is under  
19 development and considered by MAP is then picked  
20 up by the CDP process and then the CDP decision  
21 is funneled back to MAP. And the next diagram is  
22 a really good depiction of this seamless flow of

1 information where a measure that might be under  
2 development might come into the MAP process, be  
3 considered conditionally supported, be forwarded  
4 into the CDP process, and then the CDP process  
5 would analyze the robustness and the validity of  
6 the measures and it would sort of complete the  
7 infinity circle.

8 So, in the next set of slides, we will  
9 quickly go over the workgroup charge and the work  
10 to date, just to set a framework moving forward.

11 So, the dual beneficiary -- Dual  
12 Eligible Beneficiaries Workgroup provides cross-  
13 program input, primarily because there is no  
14 specific program, federal program for the duals  
15 population. They are represented in all and  
16 every federal program. The workgroup charge is  
17 to identify performance measures for use in dual  
18 beneficiary and subpopulations, prioritize  
19 measure gaps, provide strategic input for  
20 maximizing quality of life for Medicare-Medicaid  
21 enrollees. And this year, our focus is on  
22 individuals with multiple chronic conditions, as

1 well as community integration and connection to  
2 resources.

3 At the outset, the workgroup laid out  
4 a vision for high quality of care and set guiding  
5 principles. And since then, the work has evolved  
6 over the years. In 2015, MAP reviewed  
7 information to date about alignment and direct  
8 measure use experience, while considering  
9 recommendations. This year, the workgroup will  
10 refine priorities for measurement of multiple  
11 chronic conditions and dual beneficiaries as well  
12 as explore key issues related to healthcare  
13 linkages to the community and complete an update  
14 to the Family of Measures.

15 This slide shows our time line. We  
16 are here today, April 19th and tomorrow the 20th  
17 of the in-person meeting. And going forward, the  
18 milestones are the orange dots and it will be the  
19 draft report public comment and then, finally,  
20 approval through the coordinating committee and  
21 posting of the report.

22 So, this gets us to our first big

1 topic for the day, which is Multiple Chronic  
2 Conditions: Context and Emerging Policy. I will  
3 start off this presentation segment with a quick  
4 introduction and then we will hear from Ann  
5 Greiner, VP of our External Affairs and Meg  
6 McGinty, our Senior Manager of External Affairs  
7 at NQF, who will set the stage and context with  
8 the progress and current state of policy for dual  
9 beneficiaries, and the role of NQF, including  
10 recent legislature on the Hill.

11 So, who are the duals? They are  
12 individuals who are eligible for both Medicare  
13 and Medicaid, have a combination of complex  
14 clinical and behavioral issues, are socially  
15 disadvantaged and low-income. They are  
16 considered vulnerable, high need, also sometimes  
17 considered super users. They are a diverse  
18 population with respect to social, ethnic, and  
19 geographical representation. And just to give  
20 you some statistics about the finances, 20  
21 percent of Medicare beneficiaries and one-third  
22 of spending. So, it is 498.9, so basically \$499

1 billion and 14 percent of Medicaid beneficiaries,  
2 and one-third of spending. And it is \$340.5  
3 billion going in, basically \$341 billion going  
4 in. So, given these dollar amounts, there is  
5 little known about the quality of care for this  
6 group.

7 Multiple Chronic Conditions are  
8 common.

9 MEMBER MONSON: Can I just make one  
10 point?

11 DR. MUKHERJEE: Sure.

12 MEMBER MONSON: I just think it is  
13 important on that previous slide we talked about  
14 they are typically considered vulnerable. I  
15 think we should be careful about that because I  
16 don't think that is true for much of the  
17 population. Just because you have chronic  
18 conditions or you might be a dual eligible  
19 doesn't make you necessarily vulnerable. And I  
20 think that we run the risk of kind of over-  
21 medicalizing the measures as a result of that.

22 CO-CHAIR HANSEN: Michael, I think

1 that is a great point. I think vulnerability may  
2 end up being defined in a broader way, such as  
3 economic vulnerability. And that is probably it.  
4 So, rather than just the medical definition, it  
5 may be a broader definition to economic security.

6 DR. MUKHERJEE: So, multiple chronic  
7 conditions are very common among Medicare-  
8 Medicaid beneficiaries. Seventy-seven percent  
9 have documented diagnoses across two or more  
10 condition groups of physical or mental illness;  
11 forty-one percent have diagnoses across four or  
12 more condition groups; and twenty-five percent  
13 have diagnoses across five or more condition  
14 groups.

15 And the fee for service per member per  
16 month costs are higher in beneficiaries with  
17 multiple chronic conditions than those without  
18 documented conditions. Expenditures were found  
19 to be twice as high for beneficiaries with two or  
20 more comorbid conditions and four times as high  
21 for those with five or more conditions.

22 The five most common co-occurring

1 condition groups include heart conditions, mental  
2 health conditions, anemia, musculoskeletal  
3 disorders, and diabetes. Two-thirds of  
4 individuals with any condition also have a heart  
5 condition and mental health conditions are the  
6 second most common co-occurring disease.

7 Some social and demographic status-  
8 related information for beneficiaries: women  
9 have a higher prevalence of chronic conditions,  
10 also have higher rates of three or more  
11 conditions; white non-Hispanic, African American,  
12 and Hispanic groups have the highest rates of  
13 four or more condition categories; and population  
14 under age 40 consistently has the highest  
15 proportion of mental health conditions and the  
16 lowest proportion of physical health conditions.

17 And with that background, frame-  
18 setting presentation, I would like to now turn  
19 the presentation over to Ann and Meg and welcome  
20 them.

21 MS. GREINER: Thanks so much. And  
22 thanks for giving us a chance to speak with you

1       this morning about the broader policy context in  
2       which you all are doing your work.

3               We are finding increasingly that we  
4       are having the opportunity to provide technical  
5       assistance to the Hill, as they work on  
6       legislation either to reform payment or reform  
7       the delivery system and understand that quality  
8       measures are a key building block of that  
9       legislation. So, we did provide some input on  
10      MACRA, on the IMPACT Bill, on the Chronic Care  
11      Bill, which we will talk about. But  
12      congressional staff are turning to us to  
13      understand what are the measures that relate to  
14      whatever policy they are focusing on, what  
15      currently exists, what might be coming down the  
16      pipeline, what are some of the barriers to  
17      getting to the measures that would be most  
18      appropriate for the policy aims that they have.  
19      And I think we are seen by both sides of the  
20      aisle as an important technical resource.

21              It was wonderful to hear the CMS  
22      presentation this morning and to really kind of



1 get a window into all that CMS is doing with  
2 respect to duals. And obviously, it represents a  
3 big change over the last number of years.

4 So, that has been very exciting but it  
5 is also daunting to really understand the  
6 complexity of the population that you all are  
7 trying to improve the care for. And I think the  
8 folks right now in the Senate, Senate Finance  
9 that are working on the Chronic Care Bill, are  
10 also beginning to understand how complex it is to  
11 try to improve care for those with multiple  
12 chronic conditions because they are certainly  
13 taking a long time to develop their policy.

14 So, let me just go through some  
15 conduct-setting slides and then we can talk more  
16 about what we are hearing on the Hill and how we  
17 are approaching our work.

18 You know giving this presentation  
19 today, I would really like to remain close with  
20 my colleagues here at NQF to really understand  
21 how your work is progressing because I think that  
22 can be helpful, as we meet with congressional

1 staff and give them a sense of the richness of  
2 the things you are working on and maybe help them  
3 evolve their thinking. So, next slide.

4 You know this but I think it is  
5 helpful to remember that programs established  
6 separate, different benefits, financing and what  
7 that means is we obviously have different program  
8 administration and different Hill staff. So, in  
9 the same office, you have got people who are  
10 charged with working on different programs and  
11 they don't necessarily talk.

12 Obviously, early on Congress realized  
13 that there needed to be more interaction with  
14 these programs and so began to think about ways  
15 that they are linked. Forty-four years later,  
16 so, that is 1972, 44 years later, we are still  
17 working on how do we better integrate. Next  
18 slide.

19 You know I think you could say we  
20 began some modest convergence with the PACE  
21 Program. And that is a typo. It should say  
22 1997, when PACE got established nationally. And

1 we have an authority here in the room, so she is  
2 nodding her head. A truly amazing program. And  
3 I think we can be pleased that this  
4 administration saw how important it was to try to  
5 bring about more coordination between Medicare  
6 and Medicaid. And the ACA established the  
7 Medicare-Medicaid Coordination Office. I am sure  
8 that you are well aware of that. And also, you  
9 know this really using the \$10 billion that are  
10 in CMMI to focus a number of demos on the duals  
11 population. Next slide.

12 So, you know, Debjani mentioned a  
13 number of these statistics but they really are I  
14 think what get policymakers' attention. You know  
15 why do we need better integration and focus? And  
16 obviously, as the dollars go up, the cost to  
17 serve this population goes up, it gets  
18 policymaker attention. And I think they also  
19 really understand how uncoordinated and  
20 duplicative and ineffective care is and also how  
21 complicated and not everyone in the duals  
22 population but at least some have -- there is a

1 lot of complexity in terms of the kind of care  
2 that they need. Next slide.

3 So, you know over the last number of  
4 years, and you all were just talking about this,  
5 we have seen the evolution of the PACE Program  
6 and I know recently, even more flexibility for  
7 CMMI to implement this program and that is very  
8 exciting.

9 I saw a blog that Slavitt did where he  
10 basically called out that we really need to put  
11 the PACE Program on steroids and within that said  
12 that they wanted to work closely with NQF because  
13 they recognized that they needed better measures  
14 and they really needed a very good quality  
15 strategy. So, we were excited to see that in his  
16 remarks. And obviously, the work of this  
17 committee is really important.

18 We heard this morning about the  
19 Financial Alignment demonstrations and that is  
20 very exciting.

21 Caveat here. When I wrote no  
22 evaluation yet, I know that there has been some

1 qualitative evaluations but I was thinking more  
2 of the big evaluations, where you have the  
3 quantitative data and really understand how the  
4 pilots have worked.

5 I did notice that there was a GAO  
6 report saying that we need more standardized  
7 measures so that we can better understand what is  
8 happening in these alignment demonstrations and  
9 you can compare one to the other. So, that was  
10 music to our ears. Next slide.

11 So, on the Hill, what kinds of things  
12 are we talking to staff about today? We have  
13 been involved with this Chronic Care Working  
14 Group. If you have been watching this for a  
15 while, you know that this is a particular  
16 interest of Senator Wyden's and this is his  
17 second go with trying to develop a policy to  
18 address folks with multiple chronic conditions  
19 which I know is a major focus for this committee.

20 The Chronic Care Working Group is  
21 being led right now by Senators Isakson and  
22 Warner and we have had a lot of conversations

1 with them. They had a hearing I think first back  
2 in 2014 and then they asked for comments to focus  
3 on this population in May of 2015 and then we  
4 provided comments then, again, in January of this  
5 year. And they are still working to process the  
6 hundreds and hundreds of comments that they  
7 received.

8           They have put out some working draft  
9 proposals, which maybe you have seen, 30  
10 different ideas to improve care for those with  
11 multiple chronic conditions. It is a lot of  
12 different ideas. They are now working with CBO  
13 to score those different ideas and with CMS to  
14 understand how they might be implemented. It is  
15 kind of a cats and dogs -- there are some  
16 formatics for us in their proposal, very much  
17 focused on better care coordination. So, that is  
18 a goal.

19           They also think that we need to change  
20 our payment system to improve care for people  
21 with multiple chronic conditions and then they  
22 see the important role of performance measurement

1 to be able to spur improvement on multiple  
2 dimensions of care. Care coordination but also  
3 better cost control, more engagement of the  
4 patients and the providers in providing care, et  
5 cetera.

6 So, I just lifted up a couple of  
7 things in that document that has these 30  
8 different revisions. They are focused on how can  
9 we, the Medicare program, that is, do a better  
10 job of providing services in the home. They  
11 suggest maybe we should be extending Independence  
12 at Home demonstration, have a better way to have  
13 hemodialysis therapy work. They have a number of  
14 ideas related to advancing team-based care,  
15 including there is a fee paid to providers for  
16 chronic care management. And this is a new  
17 experiment to see okay, if we pay primary care  
18 providers to help better integrate care, can we  
19 get better care integration. And I think the  
20 congressional staff have looked at that and said  
21 that is very promising but maybe that is not even  
22 enough to really help those that have multiple

1 chronic conditions and a lot of very complex  
2 needs. And so, we have suggested maybe we have  
3 an even severity, a higher rate for folks who  
4 have more complex needs.

5 Also with respect to advancing care  
6 coordination, they see the importance of  
7 integrating behavioral health. And so there is a  
8 particular interest in policies that integrate  
9 behavioral health. Obviously, you all think a  
10 lot about that.

11 There is, again, they put this under  
12 the rubric of advancing team-based care. Can we  
13 make special needs plans permanent? Periodically  
14 having to extend payment for special needs plan  
15 and not make them a permanent program means that  
16 they don't have kind of a long-term horizon, in  
17 terms of managing these patients. And so they  
18 are considering things like that. Obviously,  
19 that would be quite costly.

20 There is a number of things related to  
21 empowering individuals, everything from -- I mean  
22 I am telling you it is a smorgasbord -- digital



1 coaching, flexibility for MA plans to waive cost-  
2 sharing for patients who are in ECOs, more focus  
3 on pre-diabetes care. And given the recent news  
4 from the demonstrations that have been going on,  
5 maybe that actually will make it into the final  
6 legislation.

7 And then moving along, we have also  
8 been talking to folks on the Hill related to  
9 bills to leverage new technologies. And we heard  
10 from Senator Cassidy at our annual meeting last  
11 week that they hope that bills related to, and  
12 there is a number of them, new technologies that  
13 would support telehealth and remote patient  
14 monitoring will travel with this chronic care  
15 legislation. I think that is a big if, at this  
16 point.

17 There is a number of bills in Congress  
18 related to mental health, better integration of  
19 mental and physical health. Our consultants are  
20 giving a pretty low chance of being able to get  
21 through Congress this year.

22 And I would say all of these

1 provisions, while being worked on as you all know  
2 and are reminded of every single day, it is an  
3 election year. So, the closer we get to the  
4 election, the less likely it is that these kinds  
5 of bills will get passed.

6           Nevertheless, we work closely with  
7 congressional staff because they will be taken up  
8 again, if they don't move this year, in 2017 and  
9 we want to make sure we are helping them to  
10 understand the quality picture as they work on  
11 these bills.

12           And then finally, I put SES in there  
13 because it is obviously such a hot button issue  
14 and we hear about it almost every time we go to  
15 the Hill and it affects the special needs plans.  
16 It affects how payment related to vulnerable  
17 populations and I think, again, I don't think  
18 that the bills, there is a House and Senate  
19 version of the bill, is going to move this year  
20 but Congress is certainly under a lot of pressure  
21 to try to address this issue.

22           So, you know just last page -- I mean

1 last slide, please.

2 You know if you think about it, there  
3 is certainly a lot going on and a lot of  
4 resources being put into trying to find models of  
5 care that will improve care through the dual  
6 eligible. I was really happy to hear about  
7 resources going into development of measures that  
8 are more relevant to the dual eligible  
9 population. And having an administrative  
10 infrastructure in place that is focused on  
11 integration of those two programs in the dual  
12 population is wonderful.

13 I would say we need more of that  
14 integration on the Hill because you still have  
15 these silos and there is, obviously, more work to  
16 be done so that we can get to more integration  
17 and coordination.

18 So, let me open it up for questions  
19 and Meg and I are happy to provide additional  
20 insights. Thank you.

21 MEMBER ANDREWS: My question is -- it  
22 is a question but it is also a comment.

1           I think that we all recognize that  
2       there is absolutely great value in coordination  
3       of care, certainly, when it comes to the heavier  
4       medical coordination. We talk about developing  
5       measures and gaps where measure development needs  
6       to take place but, yet we haven't really  
7       addressed the process of how that coordination is  
8       going to take place. You have primary care, who  
9       knows their area of expertise and field of care.  
10      You have behavioral that knows their area of  
11      expertise but yet there are barriers on both  
12      sides in terms of how that information is going  
13      to flow on that person-centered care, so that  
14      that care would address the whole person, not  
15      just one aspect of that person.

16           As a cardiologist, I know my stuff and  
17      when I would be in the emergency room and have  
18      somebody come in in cardiogenic shock and it was  
19      from an antidepressant overdose, yes, I know how  
20      to handle shock but I don't quite know very well  
21      the drugs that are used in the behavioral field.  
22      The psychiatrists and the behavioralist do. And

1       they also don't know whether a drug is good or  
2       not good for a particular cardiac patient, if  
3       they don't know the full details of that  
4       patient's heart status and whether drug A is not  
5       going to affect the rhythm of the heart or drug B  
6       will affect the rhythm of the heart and cause  
7       heart block and need a pacemaker for that  
8       patient.

9               So, what I am trying to say is there  
10       is information that is critical to be shared but,  
11       at this stage, the way our system is regulatory,  
12       HIPAA-related protections, intentionally for good  
13       reason, they are, however, creating barriers to  
14       that free flow of information that is critical to  
15       that best patient care.

16               Patients, at the same time, persons  
17       are afraid, even if they are asked, to sign, to  
18       have information shared because, again,  
19       regulatory-wise and otherwise, we do not have  
20       protections against discrimination just because  
21       somebody has depression. And again, as a  
22       cardiologist I know if I have somebody who is

1 depressed, I know already they are not going to  
2 be as compliant in terms of what I say or do.  
3 So, their care is going to suffer.

4 So, I guess my question and a comment  
5 is, before we start creating and trying to find  
6 ways to measure performance improvements in this  
7 particular aspect of integration and coordination  
8 of care, maybe we should be thinking much more  
9 broadly, CMS-wise and government-wise, and  
10 regulatory-wise and consumer-wise. How can we  
11 create this ability to have the free flow of  
12 information and eliminating or having checks and  
13 balances to avoid any possible discrimination and  
14 have penalties when that occurs so that the  
15 patient and the doctor can do what they need to  
16 do.

17 MS. GREINER: I do have one comment  
18 about the patient privacy around sensitive  
19 information and actually this was addressed by  
20 one of our panelists at the NQF annual  
21 conference, Deborah Peel and she works on patient  
22 privacy issues. And she explained that in Europe

1       there is much more oversight of patient privacy  
2       issues in making sure that information is not  
3       used in a discriminatory fashion. I mean we  
4       don't know, because we don't have any data, as to  
5       how prevalent it might be that information is  
6       used particularly for sensitive behavioral health  
7       issues, in a manner that would be problematic for  
8       patients. We don't know how big a problem it is  
9       in this country.

10               But it was interesting that you did  
11       say that those frameworks are in place in Europe  
12       to guard against that and there are penalties if  
13       there is any issue.

14               So, on that particular issue, there  
15       are remedies and they exist elsewhere.

16               CO-CHAIR HANSEN: That is a great  
17       comment to think about how other countries are  
18       dealing with this. But I think the journey that  
19       you just outlined speaks to a very detailed  
20       granular way to talk about coordination and best  
21       care.

22               A process comment, at this point. On

1       our calendar schedule is the fact that we would  
2       have public comment at this particular time.

3               So, for those of you with tent cards  
4       up, we will do that but the operator will need to  
5       announce to any public members who want to make a  
6       comment, that this is their opening time.

7               So, we will have time for your  
8       questions. I just wanted to point out that this  
9       is the case.

10              Operator, could you open up the  
11       comment line for anybody who might have  
12       questions?

13              OPERATOR: Yes, ma'am. At this time,  
14       if you would like to make a comment, please press  
15       \* and then the number 1.

16              CO-CHAIR HANSEN: Is there anybody in  
17       the line in the room?

18              OPERATOR: At this time, there are no  
19       comments.

20              CO-CHAIR HANSEN: There are no  
21       comments, then? All right.

22              So, why don't we --



1 MS. ANDERSON: And I am just going to  
2 ask Jim Dunford if you have joined us on the  
3 phone.

4 MEMBER DUNFORD: Yes, I have and I  
5 have no conflicts to report.

6 CO-CHAIR HANSEN: Thank you. We are  
7 so glad you could join us and we appreciate that  
8 you woke up extra early to join us.

9 Please do let us know at any time if  
10 you would like to get into the queue and I think  
11 Jennie is going to go around the room with people  
12 who raised their tent card.

13 MEMBER DUNFORD: Thank you.

14 CO-CHAIR HANSEN: Thank you. And we  
15 have two tent cards up. Joan and then Tom.

16 MEMBER ZLOTNIK: I just I guess maybe  
17 want to make a comment and I'm glad that Robyn  
18 Golden will be speaking tomorrow to us about care  
19 coordination because kind of harkening back to  
20 something someone said in the room earlier today,  
21 maybe it was Jennie, probably it was Jennie,  
22 about the 60 percent of needs that are not

1 medical or genetically related, in terms of  
2 people's healthcare needs, that the issues of  
3 sort of the care coordination sort of permeate  
4 every meeting I go to and I don't think it is  
5 necessarily a physician role. And if you look at  
6 examples like independence at home, some of them  
7 use social workers and many of them don't. And  
8 so looking at how social workers with care  
9 coordinator's roles can be enhanced and many of  
10 the CMMI innovation grants that are made actually  
11 use social workers. And I think in our last  
12 meeting, the folks from Oregon spoke about how  
13 they started out thinking they were going to use  
14 community health workers and ended up with MSW  
15 level social workers. So, I think it is really  
16 something to think about around some of the  
17 workforce issues, that when you integrate health  
18 and behavioral health, yes, clinical social  
19 workers or behavioral health providers but also  
20 social workers play many other roles in the  
21 healthcare system.

22 CO-CHAIR HANSEN: Thank you, Joan.

1 Yes, we definitely will hear more tomorrow on  
2 this.

3 Tom?

4 MEMBER LUTZOW: Yes, on this issue of  
5 adding measures to deal with multiple chronic  
6 conditions, I think there is opportunity  
7 certainly for the application of measures that  
8 stretch existing resources beyond where they want  
9 to go. And so those measures should be pursued.  
10 And I will give you an example. iCare members  
11 are in that 25 percent group that have six or  
12 more co-occurring conditions, on average. And  
13 our PMPM for medication is in the \$800 a month  
14 range. It is so high that pharmacies can afford  
15 to do in-home pharmacy services. And so we have  
16 referred about a thousand of our members to a  
17 pharmacy called Hayat Rx. Hayat Rx actually  
18 sends pharmacists in the home. They can afford  
19 to do it because of the intensity of the  
20 medication regimen. They can afford to do it and  
21 do comprehensive medication reviews, med sync, a  
22 host of other things that help with adherence and

1 enable the member to avoid having to get up, get  
2 out and go to a pharmacy to take care of their  
3 medications.

4 So, there they are a measure  
5 stretching existing resources works but it won't  
6 work all the time. And as you apply measures,  
7 states always complain about unfunded federal  
8 mandates and counties complain about unfunded  
9 state mandates. I think you need to be careful  
10 about unfunded responsibilities that come with  
11 the application of measures.

12 So, yes, I would like to hold primary  
13 care resources responsible for follow to home and  
14 in-home services and out of office outreach but  
15 it is an unfunded responsibility.

16 And we need to take a real good look.  
17 And telehealth is an example of that. It is a  
18 ball being thrown back between Medicare and  
19 Medicaid and was it really savings. And we have  
20 to stop that ball tossing and take a look at --  
21 make sure that we fund the expectation. In some  
22 cases, the resources aren't there to be

1 stretched.

2 CO-CHAIR HANSEN: I think that  
3 metaphor of unfunded delivery expectations on  
4 that. So, I just wonder Venesa, whether your  
5 team have any thoughts on as we look for these  
6 aspects. And right now, the one segment of  
7 funding my understanding is for care coordination  
8 is \$43, \$44 per contact and it is a limited  
9 amount.

10 So, any thoughts on how we achieve  
11 more integration and care coordination and the  
12 way funding exists now and how that relates to  
13 measurement and accountability.

14 MS. DAY: That is kind of like the  
15 million dollar question, it is so loaded. And I  
16 will invite my team, actually, to comment as  
17 well.

18 But I think that we are all striving  
19 to kind of get to a place where we can do all  
20 this great work and minimize the burden on  
21 everyone. I mean I wish we had some kind of  
22 great answer but I can say that it is a question

1       that we hear a lot. I don't know that I, myself,  
2       have thought of it from your perspective and I  
3       like that. And I will definitely take that back  
4       with the idea of unfunded responsibility because  
5       we do talk about, particularly in our work, about  
6       all the other things that go along with being  
7       able to treat our population. And I was actually  
8       talking to my daughter the other day about my own  
9       work and she was like well, I don't understand  
10      and all over the place. I said think about it.  
11      If you have someone and you are a doctor and you  
12      need to treat them, if they don't have a  
13      telephone, if they don't have somewhere to live,  
14      if they maybe don't have a family member, or if  
15      there is no way for you to reach out to them, how  
16      much harder is your job and your work?

17               And so what I hear in this  
18      conversation is just about that kind of unfunded  
19      responsibility because there is that additional  
20      work that you have to do, especially around this  
21      population.

22               And I think that we have programs,

1       certainly, that are trying to address that. I  
2       think there was just a grant released and forgive  
3       me if it hasn't been released, it will probably  
4       get -- but there was a grant panel that we were  
5       asked to be on for a program coming out of the  
6       innovation center that deals with kind of the  
7       idea of meeting the broader work. And I think a  
8       lot of the work that we do tries to get at that,  
9       maybe unsuccessfully but I don't have a great  
10      answer that nobody else around this table has  
11      kind of thought of already but I think it is  
12      something that we are all kind of working toward  
13      and certainly on several different levels.

14               CO-CHAIR HANSEN: I have four tent  
15      cards up. We will start with Mady. Then, we  
16      will go to Charlie, Michael, and Eliza.

17               MEMBER CHALK: A comment and an  
18      example about this unfunded business, unfunded  
19      expectations.

20               So, I mentioned earlier that I am  
21      working with CMS on the IAP measures. So, we are  
22      talking about, just to give an example, follow-up

1 after detoxification for people with substance  
2 abuse disorders. Detoxification is a medical  
3 benefit. Follow-up is a clinical benefit. So,  
4 you have got sort of -- already you have got  
5 problems about how you are going to follow these  
6 people. And this is for Medicaid beneficiaries,  
7 including dual eligibles.

8 The question arises, and I think this  
9 group needs to address it, too, about what we  
10 think measures are going to do. Are we creating  
11 some measures to drive change or are we simply  
12 measuring? The follow-up, we have no idea to get  
13 down to the granular level that George Andrews  
14 was talking about. Who is going to do the  
15 follow-up? Not a clue. Where does it happen?  
16 Does it emanate from the place that is doing the  
17 care; that is the hospital or the emergency room?  
18 Or are we supposed to have primary care reach out  
19 or substance use disorder treatment reach out?  
20 And there is no funding for it.

21 It becomes a very complex issue and  
22 all I am -- the reason I am raising it is some of



1        what we have talked about in this group are  
2        measures that may drive change if we begin to use  
3        them to focus that way, rather than simply  
4        measuring.

5                        So, when we get to care coordination,  
6        I keep thinking, okay, what are we measuring  
7        there and can this group start talking about how  
8        that is going to drive what you are talking  
9        about.

10                      CO-CHAIR HANSEN:    Carlie.

11                      MEMBER LAKIN:    Well, my life  
12        experience has really been in long-term care and  
13        primarily home and community-based services.    So,  
14        I kind of think about the world from the  
15        perspective of trying to measure outcomes,  
16        quality of life, the costs of home and community-  
17        based services.

18                      I really appreciated Tom's comment  
19        about unfunded responsibility but I am also  
20        driven to think about actual responsibility.    And  
21        I think, Mady, you pointed this out a little bit.  
22        We talk about measures around here all the time.

1 And NQF endorses measures that are viewed as  
2 valuable and valid and reliable. But less  
3 attention is really given to the system that need  
4 to be in place for these measures to mean  
5 anything.

6           You know we just don't talk about what  
7 kind of training people need to gather this data.  
8 We don't really talk about the implementation  
9 strategies, whether universal assessments or  
10 sampling that are needed to gather data that are  
11 useful. We don't talk about sampling ratios. We  
12 don't talk about universals. We don't talk about  
13 data management. We don't talk about who is going  
14 to analyze these data and present them in ways  
15 that they are going to be useful. We don't talk  
16 about how they are going to be actively involved  
17 in improving systems.

18           And you know I have had the chance to  
19 go around and see implementation of states with a  
20 couple of the long-term care measurement systems  
21 that have been developed. And I will tell you,  
22 they differ so greatly in the quality of the data

1 collection and the usability of the data that are  
2 gathered that if we don't get to that level, we  
3 have just listed a bunch of questions. You might  
4 want to ask somebody. But beyond that, I don't  
5 think we really have gotten to the depth of what  
6 is needed to really move quality among CMS  
7 programs.

8 So, that is my only thought as I  
9 listen to us talk about measures.

10 MS. GREINER: Our board has recognized  
11 this as an issue that we would like to try to at  
12 least begin to get more information on; that is,  
13 implementation experience so that it can help us  
14 to understand more about what happens when the  
15 measures move into the field. We do get some of  
16 that information but we need a lot more.

17 And so we will be doing some pilots,  
18 where we can get some more granular information  
19 about implementation. I think the other things  
20 that we think about is measures in isolation  
21 without understanding whether or not there is an  
22 evidence-based intervention also is problematic.

1       So, we have seen the biggest gains when you have  
2       an evidence-based intervention, you have got a  
3       standardized measure, and maybe even when you  
4       have a payment incentive.

5               And so I think we can't look at  
6       measures in isolation. We have to think about  
7       all these other factors and once we have a richer  
8       understanding of that, we probably will be able  
9       to identify the measures that are going to give  
10      us the best results.

11             CO-CHAIR HANSEN: Michael.

12             MEMBER MONSON: Thank you. To build  
13      on some of the comments that have been made, one  
14      of the things that we should be considering is  
15      that often these measures get designed based on  
16      the benefit packages of the programs. And one of  
17      the unique places that we sit at as the Dual  
18      Eligible Committee is that we can think about  
19      across the benefit packages.

20             So, for instance, if you think about  
21      individuals who are receiving LTSS services, it  
22      could be that they have COPD and the reality is

1       that the COPD is exacerbated because of the  
2       infestation in the apartment or the home that  
3       they have. But the measure that we might want to  
4       be looking at then is the evidence of pests and  
5       pest control, as opposed to the clinical outcome,  
6       not that the clinical outcome is not important,  
7       too. But I think that this interplay between the  
8       environmental factors and the social factors that  
9       are existing in people's lives that we are very  
10      much focused on from an LTSS perspective, will  
11      have direct downstream impacts into people's  
12      health impacts. And so if we think about the  
13      multiple chronic conditions, I just would  
14      encourage us to be thinking broadly about the  
15      determinant facts of that and how they interplay  
16      together.

17                   CO-CHAIR HANSEN: Thank you. I think  
18      our later discussion about SES factors and how  
19      that is a backdrop context will be very helpful.

20                   Eliza.

21                   MEMBER BANGIT: Thank you. Actually  
22      it is more of a comment than a question. We are

1 talking about sort of the importance of care  
2 coordination and what are the things we could do  
3 to move forward. A couple of things came to mind  
4 specifically for the Financial Alignment  
5 demonstration. I know that that is, I believe, a  
6 core element, Venesa. I am speaking to Venesa  
7 and also the MMCO folks on the call.

8           You had mentioned, I think Carolyn had  
9 mentioned that there a couple of reports that may  
10 be coming out early next year, the issue briefs,  
11 the two issue briefs that you have spoken about.  
12 I think it would be really important or real  
13 interesting to see how care coordination is  
14 working in the financial, I believe the 13  
15 Financial Alignment Initiatives, but more  
16 specifically in Colorado, which is a fee for  
17 service model. They do have regional care  
18 coordinators, which is I think the main element  
19 that changed in Colorado, in terms of how the  
20 Financial Alignment demonstration is working  
21 there. So, I think looking at their experiences  
22 and what data they are gathering and what it is

1 showing in terms of any improvements in quality,  
2 not only in the care services but quality of life  
3 of the beneficiaries who are the duals and the  
4 demonstration. So, I think that is just a couple  
5 of notes that is something to think about maybe  
6 for future reports that this workgroup may  
7 benefit from.

8 CO-CHAIR HANSEN: Thank you, Eliza,  
9 for pointing that out because, ultimately, if  
10 there is better integration of finances, there  
11 allows some flexibility within that as to how  
12 that money gets moved around by whoever the  
13 accountable entity will be. So, it will be of  
14 great interest.

15 I think we have one more question,  
16 Christine.

17 MEMBER AGUIAR: Yes, thank you.

18 I agree with a lot of the comments  
19 that we have heard. I could not agree with you  
20 more, Tom.

21 In addition, I think it is important  
22 to think about it holistically. So, measures not

1 just again for plans but for future service  
2 providers, et cetera.

3 We have been having a lot of  
4 conversations with our member plans about  
5 coordinating the care coordinators because there  
6 is responsibilities from the hospital systems,  
7 from the nursing homes as well. And so I think  
8 it is important to think not necessarily that the  
9 plans, and the hospitals, and the nursing homes  
10 have to have the same measures but that they are  
11 all not being duplicative but moving towards the  
12 same goal of population health.

13 CO-CHAIR HANRAHAN: So, it occurs to  
14 me, you know I like to think about images that we  
15 are trying to set up the dashboard on a car that  
16 we are driving when we are driving the  
17 healthcare. And if you drive in a car, there are  
18 certain very familiar parameters that are guiding  
19 you as you move along, right? You know there is  
20 the miles per hour. There is the stick shift and  
21 all of these parameters are focused around  
22 keeping you safe and efficient both in your gas



1 use and getting to the place where you want to  
2 go.

3 So, in a sense I think that what  
4 really is troublesome around these conversations  
5 for me is that we bounce between this very  
6 detailed individual level experience to the  
7 population level, which we just heard about,  
8 which I really liked the population level but the  
9 problem at the population level, especially in  
10 Congress is they start getting down into the  
11 weeds, instead of creating the car that is going  
12 to look different, no matter what community,  
13 family, individual. There has got to be an  
14 infusion of differences that we are never ever  
15 going to get to the place where we are going to  
16 be able to measure that level.

17 So, I really like what you presented  
18 because we are talking forward into this national  
19 conversation about measurement and how do we  
20 measure but if we get down into the weeds of that  
21 measurement and the detail around differences in  
22 communities. We are going to get distracted from

1        what I think is our job and that is how do we get  
2        measures that give us these same experience of  
3        miles per gallon, managing how fast we go. Those  
4        sorts of measures are really the measures that we  
5        should be really capturing at the national level.

6                And then let all of those individual  
7        PACE Programs, ACOs, the dual eligibles create  
8        the own at their level, the state level. They  
9        are always going to be the state versus the  
10       federal. We live with that and it is part of our  
11       democracy that I think is really, I believe that  
12       we want to encourage differences.

13               So, as we move forward, I would  
14       encourage us to be thinking about what are these  
15       drivers that we want to tag onto that we then  
16       will influence what kind of measures that we can  
17       determine in our dashboard as we move forward.

18               CO-CHAIR HANSEN: I'm going to, if I  
19       may, comment to Nancy's. And Tom, I will come  
20       back to you.

21               I think that your example of using  
22       that metaphor is a great one, Nancy. The ability

1 for us to, however, move through this murkiness  
2 when measurement, as we have historically known  
3 it, has been so clinically medically defined and  
4 now when we move to a whole other arena, we don't  
5 evidence-based history of even social. We have  
6 some components but to put it together in a  
7 holism is not the way healthcare has been  
8 traditionally framed. So, somehow we need to use  
9 metaphors like yours but the question I may pose  
10 back to NQA staff is whether or not other  
11 countries that have integrated social and medical  
12 care, are there ways that they are measuring that  
13 we just have not necessarily used here but could  
14 learn from? Because I saw in a couple of slides  
15 there was a discussion of Canada, as well as I  
16 forget what the Scandinavian country but is there  
17 a way to really think about that? Because right  
18 now we work with what we have.

19 The body of work that this group is  
20 going to be doing in the next day and a half  
21 takes existing measures, tweaking to some extent  
22 to kind of make a go of it, when we realize we

1 actually have moved to another country. So, how  
2 do we bridge that?

3 And then all these granular examples  
4 that cause great distress and really kind of  
5 deactivate the joy of really caring for -- that  
6 shift and are there some plans that NQF has?

7 MS. GREINER: Well, I was wondering if  
8 Nancy had been in our Board meeting because I  
9 mean you really summarized so well how the Board  
10 is thinking about how do we move forward that a  
11 recognition of trying to lift up the most  
12 important measures to help us understand how we  
13 are doing for a given population, rather than at  
14 the programmatic level so that you could say  
15 okay, how are we doing for a certain population.

16 Because we have seen that the field is  
17 asking for more guidance about what are the most  
18 important things that we should be focusing on.  
19 And so developing the criteria to get to those  
20 most important measures is something that we are  
21 going to be working on.

22 And in answer to your question,

1 Jennie, I don't know. We have been meeting with  
2 some folks outside of this country but it has  
3 been pretty episodic meetings and every time we  
4 come away saying wow, they have such insights,  
5 particularly related to integration between  
6 public health and medical and how they spend  
7 their dollars, not on health, on pop health. You  
8 know and we just keep scratching our head when we  
9 come away from those conversations. So, I think  
10 it is a really rich area for further inquiry.

11 CO-CHAIR HANSEN: Thank you. We'll  
12 have one more.

13 MEMBER LUTZOW: Yes, I have a  
14 suggestion to the issue. And no solution is  
15 common core.

16 I understand Marilyn Tavenner just  
17 came out with a blog complaining that there are  
18 too many measures. And of course we know what  
19 Donald Trump wants to do with common core on the  
20 educational side. But if there were a new domain  
21 in everybody's measure set, a common core domain  
22 that focused -- and let's make readmission

1 prevention part of that common core domain and  
2 add diabetes and some other things that are  
3 population health-focused, we would end up with  
4 collective impact and without excessively  
5 burdening anybody more than they are burdened  
6 now.

7 So, it may be that the solution is  
8 right in front of us. We don't need to take any  
9 measures away. Let's add another set of five  
10 that are common core.

11 CO-CHAIR HANSEN: Thank you, Tom.  
12 That is something to think about.

13 I will give the last comment back to  
14 Venesa at CMS.

15 MS. DAY: So, I really appreciate this  
16 conversation. Every year we leave here and I am  
17 always like we have this whole set of measures.  
18 I think last year it was like 54. And it really  
19 gives me anxiety because how did we get 54? How  
20 do we get anything moving on all of this in all  
21 of these different areas? So, a lot of what we  
22 do is trying to take what we get here and then

1 look around and see where else it exists and then  
2 try to infuse what we think about our population  
3 into what other people are doing, where we can.  
4 And that is a pretty difficult task.

5 And honestly, we have talked a lot  
6 about how to get out of that cycle because we  
7 want to have something that is real and  
8 meaningful for us because even if someone is  
9 using a measure that overlaps with us, it doesn't  
10 mean that they are using it in a way that is  
11 valuable for duals, in a way that we can use it.

12 And so this conversation around the  
13 common core, even your earlier comment about  
14 everyone pulling together around an essential  
15 issue, I feel like it would definitely, even from  
16 a process level, give us a way to direct a path  
17 forward that I feel like would be very effective.

18 So, and I think there are some  
19 measures that exist. We some repeated measures  
20 and I think maybe that might not be the way we  
21 want to go because I think last year in this  
22 group we kind of had this conversation about

1       seeing the same old measures, types of medical  
2       measures being used. But I mean, definitely,  
3       each agency has something that we could measure  
4       at a population level across the board and so  
5       that everybody, the ship is going in the same  
6       direction. It might be something definitely that  
7       we would want to talk more about.

8                   CO-CHAIR HANRAHAN: I really  
9       appreciate you saying that, Venesa. I think it  
10      really kind of summarizes what we have just been  
11      talking about.

12                   I also think that there is a new  
13      methodology that has emerged in the market and it  
14      has to do with data and how data gets used and  
15      how big the data we can process simultaneously to  
16      set up patterns. And the NQF conference focused  
17      on the reengineering of data and creating  
18      architectures that would give us the information  
19      we need that would define these core commons,  
20      which I think is really what we are seeking here  
21      is the core common.

22                   So, you know I am going to register a



1 suggestion that we need to bring onboard to these  
2 meetings people that understand these kinds of  
3 ways, methodologies for developing measures and  
4 especially if this group, which I think is a  
5 natural focus group, that we look at the core  
6 common -- thank you, Tom, for that word -- and  
7 how that core common emerges on these databases  
8 or these data points we have got simultaneously  
9 all over the place.

10 So, not only do we need a core common  
11 but we need to refresh around what is the  
12 methodology that we are engaging to move into the  
13 future about measurement.

14 CO-CHAIR HANSEN: Thank you, Nancy.

15 Last opportunity for a comment from  
16 our colleague on the phone. Jim, anything that  
17 you would like to add?

18 MEMBER DUNFORD: Sure. This is  
19 terrific. I mean as the City of San Diego's  
20 Medical Director, I think of my patients as 1.3  
21 million people today.

22 And I am looking across the entire

1 system. And one of the things that I see,  
2 whether it is acute disease or chronic disease is  
3 a lack of measures that reflect the adequacy of  
4 the governance process of the population itself  
5 and no award systems exist for doing the right  
6 thing on a population level. We have a trauma  
7 system. We have a heart attack system. We have  
8 a stroke system. Those are all acute diseases  
9 but there is money tied to a community having  
10 those systems because it does save money for  
11 Medicare patients. It does improve lives.

12 Now, we are moving to chronic disease.  
13 And again, we don't really have a governance  
14 system and I think what we really should be  
15 striving for on a national level, personally, is  
16 the definition of what is an accountable care  
17 community and reward those communities that  
18 ultimately establish them and then select tracer  
19 conditions that exemplify the types of systemness  
20 that we want. I think, again, I spent a lot of  
21 time thinking about super users. The most  
22 expensive people in my city are completely

1 disconnected, homeless, mentally ill, substance  
2 abusing. They spend the most money of all. And  
3 the lack of systemness is the number one problem  
4 that I have in terms of trying to coordinate  
5 their care.

6 And there are gaps between all of the  
7 providers that we have mentioned that really need  
8 to be filled. I use community paramedics because  
9 they connect the social workers who don't really  
10 exist in the spaces where these individuals  
11 actually resides. But is the systemness, to me,  
12 that needs to be rewarded at some point. So, I  
13 would just encourage us to continue to move this  
14 process and have measures that actually reflect  
15 and reward communities that actually get  
16 together, put their guns down at the door and  
17 think about how they are going to collaborate for  
18 the common good because a lot of these things  
19 cannot be designed by an individual accountable  
20 care community. They are really the fabric of  
21 the community itself.

22 CO-CHAIR HANSEN: Thank you very much,

1 Jim, for your eloquent summary of looking at this  
2 on a system level.

3 So, again, I thank everybody. I thank  
4 the CMS staff for being here and contributing to  
5 this, as well as our public affairs staff from  
6 NQF and the very, very thoughtful, as well as  
7 forward-leaning comments that many of you have  
8 done.

9 So, I am going to now pass this over  
10 to Debjani to be able to move us to the next  
11 section.

12 Thank you.

13 DR. MUKHERJEE: Thank you, Jennie.

14 So, the next section continues this  
15 discussion of overcoming barriers to measure  
16 development for multiple chronic conditions and  
17 we are running a little behind schedule so,  
18 instead of going through the slides, I am just  
19 going to summarize some of the issues that the  
20 slides talk about and then we can go dive into  
21 the discussion.

22 So, the main issue discussed in these

1 slides is data challenges. We don't have good  
2 data, whether it be clinical and/or behavioral.  
3 And it kind of ties into our discussion  
4 previously about big data and databases and data  
5 systems. And being a methodologist, I am really  
6 excited because there is another concept that  
7 comes along and it is skinny data.

8           So, big data are big databases, where  
9 you can get population level data and skinny data  
10 is actionable data on slices of the population.  
11 So, whether you are looking at a behavioral  
12 aspect of care or chronic disease management,  
13 either or data would be good at this point, since  
14 we don't have any and especially data that gives  
15 us a complete picture with the consumer at the  
16 center and takes into account their complex  
17 psychosocial issues.

18           We recognize that stakeholders in the  
19 arena are frustrated with the lack of progress  
20 towards priority measurement development and it  
21 is a challenge to overcome barriers to  
22 understanding and improving care needs. So, we

1       need data to improve care, to improve care we  
2       need data. It is sort of the chicken and the egg  
3       issue that we are facing.

4               So, in this slide, what we do is sort  
5       of look at some of the issues that the group has  
6       discussed already. We have looked at some  
7       measure gaps for quality of care and it has been  
8       an ongoing frustration that measurement hasn't  
9       caught up, the development of measurement, with  
10      respect to the number of gap areas. Also, there  
11      is the issue of resources and resources being  
12      devoted to bridge gaps and where is the resource  
13      going and how many gaps are being bridged, as  
14      well as barriers to measure development in  
15      complex populations.

16             So, the question to the group is how  
17      do we overcome these measure development gaps and  
18      barriers. What are some unique ways we can think  
19      about it or work around this lack of data issue?  
20      And what does ideal measurement for individuals  
21      with multiple chronic conditions look like or  
22      what should it look like? And who are the key

1 players or key sort of decision points? Or what  
2 is the tipping point?

3 MS. ANDERSON: I think I just want to  
4 also recognize one of Tom's earlier statements  
5 about the importance of measures that cross,  
6 cross different providers, cross different  
7 settings of care. And so I think that is a good  
8 place to start the conversation.

9 Is there a common core? Is there a  
10 common set of measures that should cross settings  
11 and potential providers? Is that a good solution  
12 or are there other ideas that the workgroup has?

13 CO-CHAIR HANSEN: Clarke and then  
14 Christine.

15 MEMBER ROSS: I would like to start  
16 with a common core is to focus on the beneficiary  
17 themselves. Three of our seven priority gaps  
18 that we developed in 2013 reaffirmed in 2014 and  
19 reaffirmed in 2015 are shared decisionmaking,  
20 beneficiary sense of control, autonomy, and self-  
21 determination, and community integration  
22 inclusion and participation.

1           So, rather than get into a discussion  
2 of whether diabetes is more important than high  
3 blood pressure or substance use disorder, to me,  
4 it is starting with the individual beneficiary,  
5 their experience, their quality of life, their  
6 expectation.

7           And then that means a lot of costs.  
8 So, the Council on Quality and Leadership and the  
9 personal outcome measures have been accrediting  
10 community-based organizations in the  
11 developmental disabilities and now recently in  
12 the mental illness field for almost 30 years.  
13 And when we tell the National Committee for  
14 Quality Assurance that an average audit,  
15 accreditation audit of personal outcome measures  
16 involves four days of interviewing the actual  
17 beneficiaries, a random sample of the  
18 beneficiaries. But health plans folks say, God,  
19 how much; four days? And they start multiplying  
20 the cost of surveyors. It is a lot easier just  
21 to -- whether people are on their blood pressure  
22 medicine.



1                   So, this is expensive but if we really  
2                   nod and say we all agree we should start with the  
3                   beneficiary's experience and build out from the  
4                   individual person, it means a different approach  
5                   but it also, in my mind, would avoid some of  
6                   these natural conflicts that we are going to have  
7                   between disorders and conditions and medical and  
8                   clinical and non-clinical.

9                   And we do have an evolution of  
10                  mechanisms and so on -- last comment. I was  
11                  disappointed that the CMS folks, Venesa is not  
12                  here right now, did not talk about the Medicaid  
13                  Home and Community-Based Service Experience  
14                  Survey in which we have roughly a dozen state  
15                  Medicaid agencies who have tested this for  
16                  thousands of beneficiaries. And the results  
17                  aren't public yet and the Person- and Family-  
18                  Centered Committee I think is the one that is  
19                  going to be considering it but not even to  
20                  mention that this is, you know a lot of the  
21                  advocate family and consumer movement, this is  
22                  the most exciting CMS measure area currently

1       happening.

2                   And so just an example of we nod but  
3       then we don't -- we move on to something else.  
4       So, starting with the beneficiary and their  
5       experience and expectations is what many of us  
6       are all about.

7                   CO-CHAIR HANRAHAN: I thank you for  
8       that, Clarke. The core concept, though, that you  
9       are speaking to, what would you say it is?  
10      Because I think all of those kind of segments  
11      that you just gave us, the shared decisionmaking,  
12      sense of control autonomy, community integration  
13      and participation, from an individual  
14      perspective, those are the core. But how does  
15      that then raise up to a core that would be  
16      something we could apply across populations?

17                  MEMBER ROSS: So, the National Core  
18      Indicators is an effort to aggregate the personal  
19      interviews that are conducted with beneficiaries.  
20      There is also a family interview process and we  
21      can debate whether the number interviewer or  
22      representative of the population and that is

1 another methodological question but it is how you  
2 structure -- if you adapt a CAHPS Survey  
3 appropriate to the needs of beneficiaries who  
4 live in the community and face these challenges,  
5 and we have those instruments that are being used  
6 in one little form or another, we can aggregate  
7 what people are telling us, other data folks can  
8 tell us what a meaningful aggregation of data is,  
9 based on how we ask questions and how people  
10 respond.

11 So, and I don't think this is an  
12 impossible gap. It is a gap but we can close  
13 this gap if we are serious about doing it.

14 CO-CHAIR HANSEN: I have next  
15 Christine and then Gregg, Michael, and Tom.

16 MEMBER AGUIAR: So, I was just going  
17 to say that I do agree with this idea of the  
18 common core, a core set of measures. I think  
19 especially if applied not just by provider type  
20 but across a population really is driving towards  
21 the delivery system we have formed that really is  
22 needed.

1                   One barrier to data particularly that  
2           I wanted to raise, this is something that our  
3           plans experience a lot is we call it 42 CFR Part  
4           2 and it is that even within a care team, the  
5           behavioral health providers cannot share  
6           information about substance abuse treatment with  
7           the rest of the care team without consent. And  
8           so there are some ways that either they are  
9           obviously trying to get their consent but that is  
10          a barrier that we have seen both in our Medicaid  
11          plans and in our D-SNPs and also in our duals  
12          demos plans, which have the behavioral health  
13          integrated with the long-term care.

14                   So, that is something that we are  
15          advocating for not for that privacy to not exist  
16          but for exemptions for care coordination. But I  
17          just wanted to raise that as an actual barrier  
18          towards collection and sharing of data  
19          information.

20                   And then the final thing that I just  
21          wanted to add is I have talked with the plans  
22          about providing person-centered measures, shared

1 decisionmaking, self-direction and that is a  
2 direction I think that they are supportive of.  
3 What I think I have heard from them that  
4 sometimes there is a tension between what the  
5 individual wants and what you would think is best  
6 for them in terms of quality of care. So you  
7 know selecting your own care giver and then it  
8 turns out they are monitoring their care giver.  
9 They are not actually there and sometimes it is a  
10 relative.

11 So, you can get into sticky granular,  
12 very person-specific situations. And I don't  
13 know how you develop a measure that would allow  
14 for those situations but it is just something to  
15 be aware of when moving towards what I think are  
16 very important measures to capture the patient  
17 experience.

18 CO-CHAIR HANSEN: I think you have  
19 pointed out where there is this area of conflict  
20 that many people have identified in terms of the  
21 privacy here. And somewhere we need to bookmark  
22 this and come back to it.

1                   Okay, I have then next Gregg, Michael  
2                   and whose tent card? Sorry, I can't see it.

3                   MEMBER WARSHAW: I appreciate the  
4                   discussion about trying to develop some common  
5                   measures. As a clinician working with a lot of  
6                   people with multiple chronic illnesses, a variety  
7                   of process measures only get me so far. They are  
8                   not always as helpful as they could be,  
9                   particularly in the individual cases.

10                  I am really interested in making sure  
11                  that we are assessing goals of care for  
12                  individuals that they actually communicate what  
13                  they want out of their interaction with me so I  
14                  know what their future expectations are.

15                  Like you said, not everybody agrees  
16                  with me. And so it is a negotiable thing. I  
17                  have a lot of older patients who are not that  
18                  interested in having their blood pressure totally  
19                  controlled. And I know the value of that and I  
20                  usually have to use some hard sell to get that  
21                  done but I have to work on that and make sure  
22                  they understand. Otherwise, they are not going

1 to partner with me.

2 I am also really glad to see that we  
3 have on the agenda many functional outcome  
4 measures which to me, as a geriatrician, are  
5 really important.

6 I'm not sure that we can really get to  
7 measuring value in the system and value for  
8 individuals until we are measuring function in a  
9 common way across settings, so that we actually  
10 know that what we are accomplishing is actually  
11 leaving the person more independent, more able to  
12 live in the community. A lot of times I feel  
13 like some of our treatment has too many adverse  
14 effects and we end up with a person who really is  
15 more dependent after the treatment than before  
16 and I'm not sure that is the outcome that they  
17 would have hoped for.

18 So, I'm really glad to see those  
19 functional measures. I think those will be part  
20 of the core.

21 CO-CHAIR HANSEN: Michael.

22 MEMBER MONSON: Yes, I agree with the

1 concept. The one thing that I would just point  
2 out is that in terms of a barrier, one of the  
3 barriers -- because Clarke is right, there is a  
4 cost involved with all of this, but I think what  
5 we are not doing is not leveraging the apparatus  
6 that we have already built, whether in the fee  
7 for service system or in the MLTSS system.

8 We have people visiting people in  
9 their homes on a very regular basis and  
10 collecting lots of information and we don't use  
11 it. Now, it is unaudited. So, you would need to  
12 put in some kind of auditing system to make sure  
13 that it is valid. And there are states that are  
14 doing this like New York. But this would be a  
15 way to capture a huge chunk of this data that we  
16 are talking about because that is one of the big  
17 barriers is we are missing these data points,  
18 these key data points, the functional data  
19 points. How do you know what someone's  
20 functional score is if you are not observing them  
21 in the home? How do you understand someone's  
22 quality of life without asking them questions



1       like the NCAID questions?

2               I mean we could create a system that  
3       would, it doesn't have to be a universal  
4       assessment but potentially some common questions,  
5       a common core that would go across, which would  
6       include elements at NCAID, key functional  
7       measures, key clinical quality measures, key  
8       satisfaction measures. Have it then validated in  
9       a mechanism, in an auditing type of mechanism and  
10      then suddenly, we have got a lot of rich data  
11      that we can use and we can monitor and we will  
12      really understand what is happening with people.

13              So, I think we shouldn't forget that  
14      we actually have an apparatus in place. We are  
15      just not using it.

16              CO-CHAIR HANSEN: Thank you.

17              Tom and then Aline.

18              MEMBER LUTZOW: Yes, I don't disagree  
19      with anything that has been said. We already  
20      have one measure that is part of the common core.  
21      It is readmission prevention.

22              I think the common core would need to

1 be looked at differently. Its job is maybe not  
2 to create differentiation. Its job would be to  
3 create efficiencies through collaboration. The  
4 goal would be to raise all ships.

5 And I would like to fund all  
6 expectations. And the only way to do that, given  
7 the budget neutrality principles is it generates  
8 savings so resources could be reallocated  
9 elsewhere.

10 And it seems to me the only way to do  
11 that, to get those efficiencies, is to get all  
12 horses in the team pulling the wagon in the same  
13 direction.

14 So, that is the job of the common  
15 core, to get the team pulling in the same  
16 direction. And if we do that, we are going to  
17 have money to fund telehealth and telemonitoring  
18 and other things that we feel may be unfunded  
19 expectations.

20 CO-CHAIR HANSEN: Thank you. Aline.

21 MEMBER HOLMES: So, I work in New  
22 Jersey, one of the most diverse states in the

1 country and I am also one of the 17 hospital  
2 engagement network directors for our state.

3 So, one of the things that we have  
4 been talking with CMMI is the importance of  
5 breaking down the data and especially around  
6 readmission data by race and ethnicity as well as  
7 age group. But race and ethnicity for our state  
8 is really critical because we have over 100  
9 languages spoken as primary languages in our  
10 homes and we have large populations of  
11 individuals born outside the country and  
12 expanding families. And so we have really had to  
13 start drilling down.

14 So, I think I agree with the common  
15 core but I think we have to overlay something  
16 around race and ethnicity because there are parts  
17 in this country, and it is going to continue to  
18 happen, that we are going to see increasing  
19 diversity. And what works for readmissions and  
20 the white population has no bearing on trying to  
21 work with East Asians and other populations and  
22 various populations from Central and South

1 America. So, we have to drill down and then  
2 exercise or develop interventions for each one of  
3 those populations.

4 CO-CHAIR HANSEN: Thank you. Well,  
5 that actually ties a bit to one of the segments  
6 that we are going to have.

7 And then Alice, you will have the last  
8 comment before we move on.

9 MEMBER LIND: So, if I promise not to  
10 talk about the slides again tomorrow, could I use  
11 two of my slide from my tomorrow slide deck to  
12 talk about how we addressed core measures in  
13 Washington? Do you have them up that you could  
14 slide to them really fast? At least in the  
15 previous version, they were 252-ish.

16 I just think it is kind of helpful  
17 because it seems like -- okay, so start with that  
18 252.

19 We had two different legislative  
20 mandates in Washington, about the same, actually,  
21 coming out of the session 2013 to 2014 and  
22 because of the legislature having its own

1 interests in developing common measures, two  
2 different processes were used to come up with a  
3 common set. This one that is on the slide right  
4 now is a common set of measures that was across  
5 the whole population. So, it was commercial,  
6 Medicaid, Medicare, whatever. You know it was  
7 just like if you want to look at the health of  
8 the State of Washington, here is all the measures  
9 that we think are important. It was a long,  
10 laborious process of many, many stakeholders, you  
11 can imagine, three different workgroups  
12 population measures, cost, and the clinical  
13 measures break up into prevention and acute kind  
14 of thing.

15 So, you could see they are like  
16 heavily medical, heavy, heavy medical. A lot of  
17 what the kind of same measures that we have in  
18 the duals process.

19 So then if you back one slide, the  
20 other process that was used for the Medicaid  
21 population, coming out of a whole different piece  
22 of legislation was if you are going to contract

1 out care for the Medicaid population, be it  
2 aging, behavioral health or medical, we want you  
3 to focus on more important kind of end goals,  
4 health and wellness, housing, education, criminal  
5 justice, and quality of life. And so that,  
6 again, with some overlap of stakeholders but  
7 still with that same goal of what are the  
8 important things across the whole population but  
9 now just focusing on Medicaid came up with such  
10 different measures. Some of these are kind of  
11 home-grown. We don't have standard measures for  
12 all of these things but I think it gets to that  
13 point of the question being if we don't have good  
14 coordination, what is going to be impacted.

15 So, you are going to end up with  
16 people not being housed. You are going to end up  
17 with people having more days in jail. You are  
18 going to have people who don't cycle back into  
19 the work world after they have resolved their  
20 acute condition. And I think that that process  
21 really got us to a better place, if you think  
22 about the needs of dual eligibles, it is really

1 more about wellness, quality of life and kind of  
2 ultimate outcomes.

3 So, now I won't talk about it  
4 tomorrow. So, steal five minutes from myself.

5 CO-CHAIR HANRAHAN: So, Alice, to me  
6 what you just said really represents, for lack of  
7 a better word, local work that has been done on  
8 these core issues and it is not just happening in  
9 Washington. It has been happening everywhere for  
10 about ten years.

11 And so you know I think that there has  
12 been acknowledged that we have been doing, and  
13 successfully doing, a lot of work. How can we --  
14 I think it might have been Gregg or George that  
15 said this. How can we reward these kinds of  
16 initiatives and then elevate the concept of the  
17 core concept to a population level that then gets  
18 incentivized by our federal government with money  
19 because the best incentive is money, ultimately?

20 And we are taking these measures or  
21 thinking about these measures and elevating the  
22 core and then letting our federal government

1 really manage at that population level. Where I  
2 see the federal government going, this is my  
3 personal opinion, is they start telling doctors  
4 what to do and how to do it, or they tell women  
5 what to do with their bodies, or whatever.

6 Where I want to see them really  
7 working is using the resources that -- societal  
8 resources to drive more efficiencies in the  
9 healthcare situation.

10 So, I see a few cards going up.

11 MS. ANDERSON: So we, as staff, do our  
12 best to estimate our times. And I want to  
13 recognize that we are now 45 minutes behind our  
14 agenda.

15 And thank you all so very, very much  
16 for your insightful comments. We do have another  
17 day and a half to continue to share our thoughts.  
18 And so if you have a burning 30 seconds, you are  
19 welcome to share it, Kim. Okay, you will get it  
20 in later? You want the 30 seconds?

21 MEMBER RASK: Yes. I think related --  
22 one point I was thinking about a common core is



1       that there are times where if it can be -- there  
2       are some outcome measures that are general enough  
3       that can fit in a common core, even though they  
4       are measuring what may be very different  
5       interventions and very different processes that  
6       feed into them.

7               And one quick example is we looked at  
8       medication adherence across a variety of chronic  
9       medical conditions and psychiatric conditions in  
10      our Medicaid patients and found a really nice  
11      gradient of the lowest medication adherence for  
12      our fee for service members and moving up through  
13      the various levels of care management and case  
14      management.

15              And this was case management with non-  
16      clinical case managers but we were able to show  
17      to the state that you know what, case management,  
18      even if it is not medically focused but just  
19      facilitating getting prescriptions regularly,  
20      getting them refilled, we can ensure that members  
21      are receiving more than 80 percent of the doses  
22      of the recommended medication.

1                   So, something like medication  
2 adherence can be a common sort of outcome  
3 measure. I mean the data is not full but what it  
4 is measuring is a lot of this other care  
5 coordination behind it. It is not the specifics  
6 but you could roll it up over different groups.  
7 And we have been able to use that to kind of say  
8 here are some high performance or even looking at  
9 different case management groups in the same  
10 waiver program. How come your members seem to do  
11 so much better than someone else's members on  
12 medication adherence? Are there some lessons  
13 learned or are there some things that you are  
14 doing that someone else isn't?

15                   MS. ANDERSON: That will be really  
16 helpful when we talk about a medication  
17 management measure that is no longer endorsed and  
18 talk about what we want to do in the family.

19                   So, we are going to roll right through  
20 into the next section. And I am going to invite  
21 Erin O'Rourke, as a staff member, to join me in  
22 the presentation.

1           We are going to be on slide 43, for  
2           those on the phone and in the room who have  
3           slides, and also for Janine who is so patient  
4           with us.

5           And I am going to ask you be very  
6           patient with me and to hold your comments and  
7           questions. I'm excited, too, that Erin is going  
8           to be here because we have another topic that is  
9           really going to continue to fuel the fire that is  
10          lit underneath you in this discussion about risk  
11          adjustment for sociodemographic status. So, she  
12          is going to follow some background that you may  
13          be familiar with but make sure everyone is on the  
14          same setting to talk a little bit about our  
15          family of measures and the process that we are  
16          going to undertake this afternoon to update that  
17          family.

18          And so we want to make sure that the  
19          workgroup is really full prepared to make  
20          decisions and recommendation to CMS this  
21          afternoon about the family of measures for dual  
22          eligible beneficiaries.

1           We are going to start with a brief  
2       overview about the measure selection criteria, a  
3       discussion of the National Quality Strategy  
4       priorities. We are also going to go over the  
5       current features, the family that the workgroup  
6       has previously voted on and the starter set and  
7       the gap areas that the workgroup has prioritized.

8           So, the MAP measure selection criteria  
9       -- so, MAP has developed the family of measures  
10      for dual beneficiaries as the best available  
11      measures. They are intended as a resource for  
12      those who are selecting measures within high-need  
13      subgroups and within the population of dual  
14      beneficiaries, generally.

15           So, it is an intended resource and  
16      includes a Starter Set of essential measures for  
17      the population.

18           The workgroup continues to  
19      periodically update the family of measures, by  
20      considering changes to selected measures and  
21      newly endorsed measures for their ability to  
22      address high leverage opportunities.

1           So, the MAP measure selection criteria  
2   is one of the foundations from which the MAP  
3   family of measures has been built. It includes  
4   seven different criteria and I am going to  
5   highlight some of them for you.

6           While the dual beneficiary population  
7   does not have a specific program for reporting,  
8   we heard from our CMS colleagues how they try and  
9   work across programs and make sure that this  
10   workgroup's input is importantly represented.

11          We also want to remind you and thank  
12   our liaisons this year and in the past that have  
13   represented this workgroup at the other MAP  
14   workgroups to provide input on the use of  
15   measures in federal programs.

16          I want to pay specific attention to  
17   the relevance of criteria and number five, to  
18   emphasize the importance of person- and family-  
19   centered care. We are going to hear a  
20   presentation about ongoing NQF endorsement work  
21   on this topic later today. And we are going to  
22   look at the measures that have been newly

1 endorsed under that project.

2 We also want to emphasize the  
3 importance of this criterion six, to address  
4 disparities and cultural competency in the  
5 population and in healthcare.

6 And shortly, Erin is going to tell you  
7 about some of the work NQF is doing to further  
8 understand the impact of risk adjustment for SDS  
9 status and factors to inform your decisionmaking.

10 Slide 46 lists the National Quality  
11 Strategy priorities, as they are stated by AHRQ.

12 We wanted to touch on these as an  
13 important contextual framework within the measure  
14 selection criteria. We were able to hear from  
15 our workgroup members that measure taking for the  
16 National Quality Strategy was not necessarily  
17 particularly helpful to organize the measures in  
18 the family but we also recognize it is a commonly  
19 used national framework for healthcare policy and  
20 measurement programs.

21 We also want to recognize that in the  
22 National Quality Strategy Priorities, many

1 measures could be tagged to one specific priority  
2 or, alternatively, many measures could be tagged  
3 to several if not all of these priorities.

4 So, we will discuss this more while we  
5 review the prioritization exercise results.

6 In 2012, the workgroup established  
7 these five high-leverage opportunities for  
8 measurement and priorities and the include  
9 quality of life, care coordination, screening and  
10 assessment, mental health and substance use, and  
11 structural measures.

12 On slide 47, we want to give a  
13 graphical depiction of the overview of the family  
14 of measures. And it is important to recognize  
15 that the measures have been refined over time but  
16 they really are focused on effective  
17 communication, care coordination, health and  
18 well-being, and patient safety.

19 There is a balance of measures and we  
20 recognized earlier the measure application  
21 partnership has seen more outcome measures come  
22 through on the measures on the consideration list

1 over the past several years but we still have a  
2 balance of process measures that really reflects  
3 what is available from which to select.

4 As a note, we have a Starter Set of  
5 measures. These 11 measures have been voted by  
6 the workgroup as the best available and the best  
7 in ready-to-use measures. The Starter Set is  
8 intended for those who are really starting a  
9 program or really getting the initiative to get  
10 quality measures into their setting of care.  
11 Where do I start? What do I look at? And Venesa  
12 was very representative of the overwhelmingness  
13 of the 54 measures and now 79 measures in the  
14 family. So, 11 is a lot more easy to start with.  
15 So, look here first.

16 So, the family is not only made up of  
17 the measures that are available but it is also  
18 made up of the gap areas. And we have seven gap  
19 areas that are really important. They are goal-  
20 directed, person-center care planning and  
21 implementation; shared decisionmaking; systems to  
22 coordinate acute and long-term services and



1 supports with the non-medical community;  
2 beneficiary sense of control, autonomy, and self-  
3 determination; psychosocial needs; community  
4 integration, inclusion, and participation; and  
5 optimal functioning. We are going to talk more  
6 about those separately and throughout our  
7 discussion.

8           You may remember that we vote here at  
9 NQF and we wanted to remind you that there will  
10 be a voting to maintain the family of measures.  
11 There will be voting to add or remove a measure  
12 from the family. Sixty percent is the threshold  
13 for workgroup consensus. So, there may be a yes  
14 or a no but either has to achieve 60 percent.

15           And Janine was so kind as to remind  
16 how to do that and help us use the clickers. If  
17 you have any questions about that as we go,  
18 please don't hesitate.

19           So, we have also looked at, as a staff  
20 preliminary analysis considered the measure  
21 selection criteria, the priorities for  
22 measurement, high-leverage opportunities, and gap

1 areas. And we have provided that input on your  
2 slides as you can consider the measures that have  
3 been newly endorsed or the measures that are no  
4 longer endorsed.

5 And these staff preliminary analyses  
6 are places for us to start the conversation and  
7 we will be able to vote on staff picks, if you  
8 choose, but they are definitely not a  
9 predetermined decision.

10 So we had a workgroup prioritization  
11 exercise. Thank you to the eight of you who  
12 responded. It is not a great response rate. But  
13 six measures were identified as low priority and  
14 we are going to consider those for removal. Two  
15 have had endorsement removed.

16 There was also measures that were  
17 identified as high priority and those are  
18 measures that have had six or seven votes for  
19 high priority and those will be considered for  
20 inclusion in the Starter Set on Day 2.

21 In the middle, we have measures that  
22 were not identified as low priority and measures

1 that were identified as low priority by only one  
2 person.

3 So, these measures, we, as staff, have  
4 kind of determined that there is really no  
5 change. We are didn't see those as a cause for  
6 removal and we also didn't see that as enough  
7 threshold to move to the Starter Set.

8 Some themes from the prioritization  
9 exercise. There is a focus and a concentration  
10 on available measures that doesn't necessarily  
11 mismatch the population needs, including acute  
12 care measures, though we have heard from you all  
13 today already how much the beneficiaries really  
14 rely on post-acute and long-term care settings.

15 The impact of behavioral health and  
16 mental health issues is significant, while there  
17 is so much focus on the medical physical model of  
18 available measures.

19 And we wanted to recognize that  
20 screening assessment measures need to include  
21 elements of treatment and follow-up.

22 There so there are also recognized few

1 available measures that represent PFCC and the  
2 member's perspective, measures that very few or  
3 very limited measures that would be meaningful to  
4 individuals.

5 We want to also recognize the theme  
6 that there were a lot of support for measures  
7 that promote effective communication, care  
8 coordination. We have talked about that a little  
9 bit already today.

10 And we want to recognize that the NQS  
11 priorities created some confusion but we hope  
12 that our structure of the meeting today does not  
13 compound that and alleviates that.

14 And while we do have a lot of measures  
15 that have been voted into the family, we want to  
16 also recognize that there is a real need to be  
17 parsimonious or really have focus and limit the  
18 number of measures that are included in the  
19 family.

20 So, throughout Day 2, we are going to  
21 ask you to consider measures that should be  
22 removed from the family. We are going to ask you

1 to consider measures that have been newly  
2 endorsed for addition to the family. And we are  
3 going to be prioritizing measures into the  
4 Starter Set on the beginning of Day 2 and a  
5 reminder that greater than 60 percent is  
6 agreement on consensus.

7 I am going to pause for a drink of  
8 water and also introduce my colleague, Erin  
9 O'Rourke, who I have had the pleasure of working  
10 with for four years and who I know is going to  
11 provide you some really, really interesting  
12 information on risk adjustment.

13 MS. O'ROURKE: Thanks, Megan. And  
14 thanks to all of you for having me here today. I  
15 will try to be brief because I know I am the one  
16 standing between you and a delayed lunch.

17 I did want to give you just a quick  
18 overview of NQF's trial period for SDS  
19 adjustment. Just to cover a little bit of  
20 background, some of the varying views on why or  
21 why not to do these adjustments, just to explain  
22 the policy change to all of you, share a little

1 bit about the trial period, what we are doing,  
2 how it is impacting the measure evaluation  
3 process, and then share a little bit about the  
4 potential implications for your Family of  
5 Measures. Next slide.

6 So, just to give some quick background  
7 and make sure we are all on the same page, I did  
8 want to define risk adjustment and explain a  
9 little bit about why performance measures are  
10 risk-adjusted.

11 So, risk adjustment is a statistical  
12 approach that allows patient-related factors such  
13 as comorbidity and illness severity to be taken  
14 into account when calculating performance measure  
15 scores. This improves the ability of a measure  
16 to make fair and correct conclusions about  
17 quality.

18 As you know, NQF endorses performance  
19 measures that are intended for use in  
20 accountability applications, such as public  
21 reporting and pay for performance. So, in this  
22 context, the measure score is being used to make

1 a conclusion about a provider's quality in  
2 relation to either other providers or some  
3 comparator such as a national average performance  
4 because healthcare outcomes are a function of  
5 both patient attributes, as well as the care  
6 received. And patients are not randomly assigned  
7 to provides for healthcare services so that all  
8 providers would have the same mix of patients.  
9 Risk adjustment is essential to examine outcome  
10 performance in the real world.

11           Essentially, the purpose of risk  
12 adjustment is to provide like-to-like comparisons  
13 and without appropriate risk adjustment,  
14 providers can be misclassified based on incorrect  
15 conclusions about their performance. So, really  
16 the general question we are trying to address is  
17 how would the performance of various providers  
18 compare if, hypothetically, they had the same mix  
19 of patients? That is, if the measure scores are  
20 being used to identify which providers have  
21 better quality in order to inform the decision of  
22 a consumer about where to seek care, a purchaser

1 about whether or not to pay for care, or give a  
2 bonus or a penalty, a payer, how they would be  
3 setting up their network and awarding contracts,  
4 these comparisons should really be affected as  
5 little as possible by factors other than the  
6 quality of care. And that can include patient  
7 characteristics already present at the start of  
8 care. Next slide.

9           So, I know sociodemographic status is  
10 not a term that everyone uses. So, just to  
11 quickly define that, when we say sociodemographic  
12 status, we are referring to a variety of  
13 socioeconomic, such as income, education, and  
14 occupation, and demographic factors, such as age,  
15 primary language, household income and zip code.  
16 There is a growing body of evidence demonstrating  
17 the association between patient SDS and  
18 healthcare outcomes. And additionally, we have  
19 seen a dramatic policy shift in recent years to  
20 value base purchasing with really an increased  
21 focus on outcome measures in those pay for  
22 performance programs.



1                   However, in general, caring for a  
2                   sociodemographically disadvantaged populations is  
3                   associated with poor performance on the current  
4                   performance measures. And that is just on  
5                   average there are some noteworthy exceptions to  
6                   that general pattern. And given the higher  
7                   financial stakes, especially for safety net  
8                   providers, we want to ensure that the measures  
9                   are really giving that apples to apples  
10                  comparison between providers.

11                  We want to ensure that the safety net  
12                  providers aren't being unfairly penalized because  
13                  of the population that they serve. Doing so  
14                  could create greater disparities or take away the  
15                  additional resources that are needed to serve  
16                  vulnerable populations and close those gaps in  
17                  care.

18                  So, historically, SDS adjustment of quality  
19                  measures has been avoided. We know there are at  
20                  least two divergent views on adjusting measures  
21                  for SDS status. Interestingly, both of these  
22                  positions are really anchored and a shared

1 concern about worsening disparities in the  
2 healthcare system.

3 Those who oppose adjusting the  
4 measures for SES feel that doing so will mask  
5 disparities. They feel providers may deliver  
6 worse quality care to disadvantaged patients,  
7 adjustments could mask meaningful differences in  
8 quality. It sets a stage that perhaps worse  
9 outcomes could be expected. There might be no  
10 expectation to improve. It implies or sets a  
11 different standard for those serving vulnerable  
12 population.

13 I know that I don't really need to  
14 tell this to this group, as I just heard your  
15 previous conversation but there is a lack of  
16 adequate data to do these adjustments and others  
17 prefer a payment approach to help the safety net  
18 rather than adjusting the measures.

19 Those who support SDS adjustment feel  
20 that it is really necessary for comparative  
21 performance. And a performance score alone,  
22 whether or not it is adjusted for SDS factors

1 cannot identify disparities. They feel hospitals  
2 caring for the disadvantaged are already being  
3 penalized. And there is no evidence that  
4 disparities would be reduced through further  
5 negative financial incentives.

6 And finally, that a lack of adjustment  
7 would create a disincentive to care for the poor.

8 Next slide.

9 So, to consider an adjust these  
10 issues, NQF convened an expert panel to determine  
11 when and how quality measures should be adjusted  
12 for SDS factors. This went through the typical  
13 NQF process. We convened an expert panel  
14 composed of multiple stakeholders with a variety  
15 of experiences. And the recommendations were  
16 submitted for public comment and then modified in  
17 response to the comments received. Next slide.

18 The expert panel developed a set of  
19 core principles to really ground their  
20 recommendations. They noted that outcome  
21 performance measurement is critical to the aims  
22 of the NQS. They felt disparities in health and

1 healthcare should be identified and reduced.

2 Performance measurement should not  
3 lead to increased disparities. They noted  
4 outcomes may be influenced by patient health  
5 status, clinical and sociodemographic factors, in  
6 addition to the quality and effectiveness of  
7 healthcare services, treatments, and  
8 interventions. Next slide.

9 When used in accountability  
10 applications, measures that are influenced by  
11 factors other than the care received,  
12 particularly outcome measures, need to be  
13 adjusted for relevant differences in the case mix  
14 to avoid incorrect inferences about performance.

15 They noted risk adjustment may be  
16 constrained by data limitations and data  
17 collection burden. And the methods factors and  
18 rationale for risk adjustment should be  
19 transparent. Next slide.

20 So, based upon the recommendations of  
21 this expert panel, NQF ultimately decided to  
22 undergo a two-year trial period where performance

1 measures could be adjusted for SDS factors. This  
2 is prior to a permanent change in NQF policy.  
3 Previously, there had been a prohibition on the  
4 consideration of sociodemographic factors in risk  
5 adjustment. NQF preferred to see stratification  
6 based on these variables.

7 So, during the trial period, if SDS  
8 adjustment is determined to be appropriate for a  
9 given measure, NQF will endorse one measure with  
10 specifications to compute the SDS adjusted  
11 version, the non-SDS version, that is, one that  
12 is only clinically adjusted to allow for  
13 stratification. Next slide.

14 The trial period really stresses that  
15 each measure must be assessed individually to  
16 determine if an SDS adjustment is appropriate.  
17 And not all outcome measures should be adjusted  
18 for these factors. In particular, an example  
19 such as CLABSI should not be adjusted, something  
20 where the stat and the end of the process is  
21 really under the control of the provider would  
22 not be appropriate.

1           There needs to be both a conceptual  
2 basis, that is a logical rationale or a theory,  
3 as well as empirical evidence to support the  
4 adjustment.

5           And finally, these recommendations may  
6 apply to any level of analysis, such as health  
7 plan, facility, and individual clinicians. Next  
8 slide.

9           So, all measures submitted to NQF for  
10 endorsement after April 15th of last year are  
11 considered to be part of the trial period and the  
12 standing committees evaluating them, they  
13 consider if the measure is appropriately adjusted  
14 for SDS factors. So, this includes newly  
15 submitted measures, measures undergoing  
16 endorsement maintenance, measures that were  
17 conditionally endorsed, such as the ones in the  
18 Admissions/Readmissions Project and the Cost and  
19 Resource Use Projects, as well as measures  
20 undergoing an ad hoc review. Next slide.

21           So, this slide just shows some of the  
22 questions that the standing committees are asked

1 to review when they are considering an SDS-  
2 adjusted measure. They are asked to look if  
3 there is a conceptual basis between the SDS  
4 factor and the measure focus; if the factor was  
5 present at the start of care; if there is  
6 variation in the prevalence of the factor across  
7 measured entities; if the empirical analysis that  
8 the measure developer provides shows that the  
9 factor has a significant and unique effect on the  
10 outcome and if the information on that SDS factor  
11 is available and generally accessible. Next  
12 slide.

13 So, this does have some implications  
14 for the Dual Eligible Beneficiaries Family of  
15 Measures. So, we wanted to make sure you were  
16 aware of the trial period and the potential  
17 impact. Five measures in the family are  
18 currently part of the trial. There are five  
19 measures from the recent Readmissions Project.  
20 That project began and ended just prior to the  
21 start of this trial period and throughout that  
22 project, we heard there were concerns about the

1 need for potential risk adjustment for SDS  
2 factors on these measures. Because of that,  
3 these measures were endorsed with the condition  
4 that they enter the trial and that the Standing  
5 Committee determine if there is a need to adjust  
6 these measures for SDS factors.

7 So, just to give you a quick update on  
8 that work, the Admissions/Readmissions Standing  
9 Committee is currently in the process of a series  
10 of meetings to review the 16 measures that were  
11 endorsed with this condition.

12 Some findings from the Standing  
13 Committee's preliminary review are on this slide.

14 The Standing Committee had concerns  
15 that the variables currently proposed by the  
16 developers may not be sufficiently robust,  
17 however, there is also a need to consider current  
18 limits to the availability and accessibility of  
19 data around these factors.

20 The Standing Committee noted that any  
21 patient characteristic that is present prior to  
22 treatment or is a known or suspected confounder



1 of the treatment may be included in the risk-  
2 adjustment model.

3 The committee encouraged consideration  
4 of age, gender, and some measure of poverty, as  
5 well as to test community-level variables when  
6 patient-level data were not available for  
7 sufficiently robust.

8 The committee noted that geographic  
9 proxy data should match the actual SDS  
10 characteristics of the patient as accurately as  
11 possible. So, I would strongly encourage use of  
12 a 9-digit ZIP code as a 5-digit might too broad  
13 brush.

14 And finally, the committee strongly  
15 urged caution on the use of race as a proxy for  
16 patient SDS, as it is really difficult to assess  
17 the underlying concept that that is measuring.  
18 Next slide.

19 So, to date, we have learned quite a  
20 bit about the challenges of risk adjusting  
21 quality measures for SDS factors. As you all  
22 were just discussing, there is really limited

1 available data of patient-level data, in  
2 particular the 9-digit ZIP Code/census block data  
3 that can really show the granular differences  
4 that we need. It is not easily accessible.

5 Risk models using currently available  
6 adjusters are not really demonstrating an  
7 association for measures with a clear conceptual  
8 basis for SDS adjustment.

9 We have heard some concerns about the  
10 factors selected and being analyzed to date.  
11 Available proxies may not be adequate. There has  
12 been concern about the use of race as a potential  
13 factor, as well as a call for a more prescriptive  
14 approach. Historically, NQF has not been  
15 prescriptive in its approach to the variables  
16 included in risk-adjustment models or the method  
17 used for risk adjustment. That is for the  
18 developers to determine and the Standing  
19 Committees, too, then evaluate what the  
20 developers put forth and that applies to both  
21 clinical and SDS factors. However, questions  
22 have arose about whether NQF should establish

1 guidelines for what factors should be considered  
2 to ensure a more consistent and thorough trial  
3 period.

4 So, with that, I will turn it back  
5 over to Jennie for discussion. I am happy to  
6 take any questions.

7 CO-CHAIR HANSEN: Any immediate  
8 responses, like comments like Thomas, your card's  
9 up?

10 MEMBER LUTZOW: Yes. I noticed that  
11 the measure, the measures list had a lot of  
12 adjusted, and the answer was no or yes. So in  
13 voting on the measure are we voting that it be  
14 accepted as an unadjusted measure when, in fact,  
15 CMS itself did the RAND study, has determined  
16 that that measures is affected by SES. Are we  
17 overriding anybody in voting for a measure as  
18 it's presented when we know, in fact, that it is  
19 affected by SES?

20 MS. ANDERSON: We are considering  
21 measures as they are currently endorsed. The  
22 measures that we have for you today and the

1 measures that are currently in the family are  
2 endorsed, some with risk adjustment, for clinical  
3 factors generally or other severity factors.

4 The trial period is new and  
5 informative, but we don't have any measures that  
6 are truly affected by -- with a decision to  
7 endorse the measure with risk adjustment for SDS  
8 factors at this time. We have in the past, and  
9 the workgroup could recommend, and participate in  
10 an infinity loop as Debjani earlier described,  
11 that we provide input to the CDP process about  
12 measures that have been endorsed or are going  
13 through the trial period, we can provide input  
14 and feedback as the question asked about  
15 recommendations to the steering committee.

16 MEMBER LUTZOW: So --

17 MS. ANDERSON: In addition --

18 MEMBER LUTZOW: -- no one's going to  
19 misunderstand our vote if we approve a measure  
20 that we feel should be SES adjusted. It isn't  
21 yet. CMS isn't going to misunderstand our vote  
22 that we're endorsing it as an unadjusted measure?

1 MS. ANDERSON: We can precisely  
2 include that information when a measure is voted  
3 for inclusion in the family, and strong  
4 encouragement for risk adjustment for SDS  
5 factors.

6 MEMBER LUTZOW: The other question is  
7 it seems that the sponsors are not consistent in  
8 their assessment of SES impact at the very  
9 beginning of the development of the measure.  
10 Isn't there a need before the sponsor presents a  
11 measure for them to provide information on is  
12 this impacted by SDS or not? And use a common --  
13 and, again, you have pointed out there is no  
14 common methodology -- isn't that a fundamental  
15 weakness here?

16 MS. O'ROURKE: Sure. So we do ask the  
17 developers to submit that information on the  
18 measure submission form that they fill out when  
19 they put a measure forward for NQF evaluation for  
20 potential inclusion -- or potential endorsement.  
21 So we are collecting that information about the  
22 conceptual basis. They're asked to either say if

1       there is or is not, and justify basically why or  
2       why not SDS adjustment.

3               The lack of a standard methodology, we  
4       have heard that as a concern. That's  
5       historically how NQF has treated risk adjustment  
6       for clinical factors, so we are keeping that  
7       policy consistent. But we know that that has  
8       been raised as a potential limit to the trial.

9               CO-CHAIR HANSEN: Just a clarifying  
10      question.

11              Given what we know, the unevenness  
12      right now and the fact that the trial goes on,  
13      how will the findings actually be interpreted  
14      and received?

15              MS. O'ROURKE: Sure. So the trial is  
16      really at its essence about testing this policy  
17      about lifting a prohibition. So it would really  
18      be in a year taking a look at whether we would  
19      want to put that prohibition back in place and no  
20      longer allowing SDS factors to be considered in  
21      risk adjustment models, or continuing with this  
22      policy of allowing them to be on the table and

1 the developers to make that decision about  
2 whether or not they would put forward their model  
3 with those factors in.

4 So we know there's challenges about  
5 getting to some of the bigger picture questions  
6 about the impact of using adjusted or non-  
7 adjusted measures. We don't expect we'd be able  
8 to answer those in the two years that we have.  
9 So we're really trying to test this policy and  
10 see if it's something that we would want to make  
11 a permanent change.

12 CO-CHAIR HANSEN: And just to answer  
13 Tom's comment then, perhaps after two years it's  
14 really clear that some framework needed to be  
15 developed. And that might be one possible  
16 outcome to, you know, continue this process.

17 And two more cards, Christine and then  
18 Mady.

19 MEMBER AGUIAR: So my question is, if  
20 the committee in doing its research finds that  
21 perhaps the best, most reliable data to do the  
22 risk adjustment is something, so income for

1 example, something that perhaps is collected by  
2 census but not collected by CMS currently, could  
3 the committee recommend to CMS that this  
4 particular data needs to be collected? Or is the  
5 committee confined to working with the data that  
6 Medicare currently collects?

7 MS. O'ROURKE: So that has been one of  
8 the big challenges in the measures that we've  
9 currently seen come in on the endorsement side.  
10 A lot of the developers are -- do feel they're  
11 constrained to what's currently available in the  
12 claims data. So it's an evolving process of  
13 encouraging developers to look at different data  
14 sources, perhaps additional data to be collected.

15 There's not really an easy answer  
16 there. But the committees do have a chance to  
17 provide some more qualitative input, if you will,  
18 and make those types of recommendations that  
19 developers look beyond what's currently in the  
20 claims data.

21 MEMBER CHALK: So is this committee,  
22 our committee going to have access to the



1 information on the committee that I was involved  
2 with yesterday on the development of measures,  
3 which is the IAP various committees? Because  
4 yesterday we were talking quite specifically to  
5 people who are going to be the developers about  
6 having to include poverty as a factor in looking  
7 at all-cause readmissions.

8 Now, so here we go with one group of  
9 people talking to developers about including  
10 poverty. And here we're studying it as a risk  
11 adjustment factor. I just want to know that the  
12 right hand of CMS is talking to the left hand of  
13 CMS since --

14 MS. DAY: So are you asking about the  
15 TEP?

16 MEMBER CHALK: Yes.

17 MS. DAY: Yes. So we're all involved,  
18 so we hear the information. Yes, we are aware.  
19 The TEP process is through a contracting process,  
20 so it is separate. But that's part of why we  
21 have people like you and us sitting on -- yes.  
22 So we have to bring, we're responsible for

1 bringing the information.

2 But we do know from one to the other  
3 what's happening.

4 MEMBER CHALK: So that's just a piece  
5 of information now for this group, that the  
6 developers of the measures from the TEP group  
7 were asked to pay attention to poverty as an  
8 issue in readmissions.

9 CO-CHAIR HANRAHAN: You know, poverty  
10 has been, you know, factored in as a digesting  
11 factor for a long time. It's basically using  
12 whether or not that individual is receiving  
13 Medicaid. And that gives you the poverty  
14 guidelines, federal guidelines.

15 What I've heard being -- that's really  
16 interesting to me is that the recommendation is  
17 to move from a 5-number --

18 MEMBER CHALK: To a nine.

19 CO-CHAIR HANRAHAN: -- ZIP code to a  
20 9-number ZIP code. And I don't feel like we have  
21 -- and then we're being asked to say whether or  
22 not we're recommending SDS adjustment for the

1 readmission committee. And I just don't have  
2 enough information because I don't know what the  
3 margin of error is between a 5-digit ZIP code and  
4 --

5 MEMBER CHALK: And a nine. And  
6 neither do I.

7 CO-CHAIR HANRAHAN: -- and a 9-digit  
8 ZIP code, you know. And maybe now 5-digit ZIP  
9 codes we know we can get that. And we know that  
10 we can't get the 9-digit ZIP code very easily.

11 MS. O'ROURKE: Sure.

12 CO-CHAIR HANRAHAN: You know, can you  
13 guide us a little more on that?

14 MS. O'ROURKE: Sure. So that type of  
15 decision about whether you'd adjust it to 5-digit  
16 or 9-digit level is really with the developers to  
17 make that decision about what they can do and  
18 what model they want to put forward, and then the  
19 standing committee, too, they can make an  
20 endorsement decision about whether the measure is  
21 valid.

22 What we're really hoping for from this

1 committee is some guidance as end users of these  
2 measures and experts in vulnerable populations,  
3 about are there any special considerations that  
4 you've seen around these readmissions measures  
5 that you'd want the standing committee to be  
6 aware of as they're evaluating that.

7 And we do know that the 9-digit ZIP  
8 code has been a challenge. It's really been  
9 something the standing committee's wanted to move  
10 forward with, as when we see the analysis on the  
11 5-digit ZIP code, nothing is showing up. It's  
12 showing there is no difference. So I think  
13 there's been some concern that 5-digits is just  
14 not granular enough and perhaps 9-digits would  
15 show greater differences. But we know it's  
16 challenging and it's not easily available.

17 So that's really just an update on the  
18 status of the data.

19 CO-CHAIR HANSEN: But does it show  
20 results --

21 MS. O'ROURKE: In some preliminary  
22 studies it looks like it has, a little bit in the

1 literature. But I think there hasn't been a -- I  
2 mean I'm not fully, fully versed on that so I  
3 don't want to make a definitive statement -- but  
4 from what we've found, it seems a bit in the  
5 literature but not -- we haven't had a measure  
6 submitted that's been adjusted at the 9-digit  
7 level and endorsed.

8 CO-CHAIR HANRAHAN: I just know that,  
9 and we've talked about this a lot, about how  
10 income impacts health outcomes. So, you know, at  
11 that level I think we should be recommending that  
12 there be an SDS evaluation or adjustment. But  
13 the detail of that, you know, is really the  
14 devil's in the details and how they want to move  
15 that forward.

16 But you're asking us to recommend,  
17 make a recommendation to the readmissions  
18 standing committee. I mean how do others feel  
19 about this socio-economic status being part of  
20 adjustment; that being the question, right?

21 MS. O'ROURKE: Yeah, I think that I  
22 will be able to input a little bit more on this.

1 You know, there's people who are strongly in  
2 favor of the adjustment, others who oppose it  
3 very strongly. So as experts around the room  
4 serving vulnerable populations, what would you  
5 say the pros and cons are?

6 CO-CHAIR HANSEN: We're scheduled for  
7 picking up lunch but we will actually have a  
8 working lunch as well. So we have moved toward  
9 the side of making sure people are -- comments,  
10 George.

11 MEMBER ANDREWS: Yeah. Out of  
12 curiosity, typically when I'm thinking of SDS, I  
13 would think that there is a whole set of  
14 variables that could play into that  
15 categorization. And so my question is has  
16 anybody, has -- I would hope that some form of  
17 covariate analysis testing has been done to  
18 assess all of those variables and determine which  
19 ones appear to have an impact on risk adjustment.

20 And then from that set, then ask the  
21 question, okay, does it make sense to incorporate  
22 any of these or all of these, because they are

1        impacting the risk adjustment independently of  
2        each other?

3                    MS. O'ROURKE:    Sure.    So that's really  
4        what we're asking the developers to do in the  
5        empirical analysis.    They're asked to submit for  
6        their measure endorsement.    We asked them what  
7        factors they had available, what the impact of  
8        each factors was, and as well as the conceptual  
9        basis for including or not including.

10                   MEMBER LUTZOW:    Yes, in addition to  
11        SDS, disability is another factor.    And I'm sure  
12        you have a copy or could get a copy of the RAND  
13        study that CMS commissioned at the end of last  
14        year that showed the disability on top of poverty  
15        as a double whammy.

16                   I'd like to pick up on this idea that  
17        creating a framework that requires sponsors to  
18        test for SDS disability impact as part of their  
19        submission process, and a common method of  
20        measuring that.    Now, I understand the data  
21        problem, but the method is not a problem.  
22        Standard statistical procedures ought to work

1 fine. Or, you know, logistic regression ought to  
2 work fine. It's a question of, as mentioned by  
3 Andrew, the covariates of the data sets that are  
4 used.

5 But, you know, can we agree at least  
6 on the set of criteria that need to be considered  
7 when even presenting a measure? It has or it does  
8 not have SDS effect; it has or has not disability  
9 effect. Those are answerable questions.

10 CO-CHAIR HANSEN: Okay. I think  
11 that's definitely registered. Good point.

12 Christine.

13 MEMBER AGUIAR: So to the extent that  
14 the question on the table is whether measures  
15 should be adjusted for SDS, yes, as an  
16 organization this has been one of our biggest  
17 tasks at CMS, both really with respect to the  
18 Star Rating program, the Medicare Advantage Star  
19 Rating Program, and then also in the risk  
20 adjustment system.

21 In the Star Rating program we've been  
22 calling for stratification. We're not -- but



1 we're, you know, we're open to other  
2 possibilities, whatever research shows is the  
3 best way to actually risk adjust. But that is an  
4 idea that we have been asking for CMS to test,  
5 really because it makes sense to our plans to  
6 compare like plans to like plans, which is not  
7 currently done in the Star Rating system. But  
8 that's open to other means of risk adjustment.

9 I would just, again, echo and add to  
10 what Tom was saying that, you know, when we talk  
11 to our plans about the issues that they have, and  
12 again this is in the context of the Star Rating  
13 system, they are working to make improvements,  
14 working with the providers to improve those  
15 quality measures.

16 And then what many of our members find  
17 is that there's sort of a ceiling where because  
18 of the nature of who these individuals are and  
19 all of their challenges, that is what is getting  
20 in the way of them, you know, getting the care  
21 and so it's getting in the way of the performance  
22 on the Star Rating system.

1 Which are the exact, you know, risk  
2 adjusters to use? I don't know. What I could  
3 just report back to you is that what we hear is  
4 there really is a difference in the full benefit  
5 individuals, the lowest income individuals. They  
6 are different than other Medicare beneficiaries.  
7 And CMS just acknowledged this and you see it's  
8 reflected in the recent change to the risk  
9 adjustment system, where CMS really did find  
10 clinical and cost distinct profiles for full  
11 benefit individuals, but also individuals with  
12 disabilities.

13 Other populations that we hear that  
14 have unique challenges, even within individuals  
15 with disabilities, are those with behavioral  
16 health conditions, the SPMI population and then  
17 individuals that have co-morbid depression and  
18 anxiety and other mental health conditions on top  
19 of multiple chronic conditions.

20 And then the other populations that we  
21 hear are very distinct is also the individuals  
22 with housing security and homeless, et cetera.

1           So all that is to say that I am very  
2       supportive of looking into -- of actually  
3       adjusting measures. It'd be great if the  
4       committee could also look into stratification. I  
5       think you said that it sounded like maybe you  
6       looked into that and that wasn't -- you weren't  
7       going to continue to pursue that. But I think it  
8       is incredibly important, I think both for,  
9       obviously, you think about it from a payment  
10      perspective in the Medicare Star Rating system,  
11      but also from the measuring and reporting back to  
12      stakeholders the true quality of care.

13           MS. O'ROURKE: Sure. And just to  
14      clarify, previously the NQF policy only  
15      supported stratification. So this new policy  
16      really brings risk adjustment into the mix as  
17      well. But we would -- if a measure does include  
18      SDS factors, we do require that there be a  
19      clinically adjusted version only made available  
20      so that people can continue to stratify.

21           MEMBER MONSON: Are we voting now?

22           MS. O'ROURKE: No. This is just a

1 FYI.

2 CO-CHAIR HANSEN: That's the intent of  
3 this presentation because many of us have been  
4 hearing about this SES work that NQF has  
5 committed to, so we've been asking for kind of a  
6 progress report along the way as we are asked to  
7 make other kinds of decisions. And I think we're  
8 bringing up other, you know, element of whether  
9 it's a 5-digit or whether it's a framework that  
10 we think is real important as we consider all of  
11 our measures.

12 So with that I see Clarke's about  
13 ready to -- I was going to close up the section  
14 here. Is there something, Clarke, that's part of  
15 this or can this be another discussion?

16 MEMBER ROSS: I wanted to ask a  
17 question about we have data on historically  
18 discriminated populations. And we have data on  
19 their disparity in utilization of certain health  
20 services.

21 So I'm thinking about women who use  
22 wheelchairs and they die on average earlier than

1 the rest of the female population in our society  
2 because of lack of access to accessible  
3 mammography. If we didn't have discriminatory  
4 practice and we had accessible practices we  
5 wouldn't have to adjust, but we don't.

6 And so how, how does the group build  
7 discriminatory practice that results in disparity  
8 into these adjustments?

9 MS. O'ROURKE: So that's an excellent  
10 question and one that I don't have an exact  
11 answer for you on. But we have convened a  
12 disparity standing committee that is taking a  
13 look at these types of issues and monitoring  
14 things like that to ensure that doing these  
15 adjustments doesn't worsen disparities because we  
16 know there are issues around discrimination and  
17 bias that we do not want to adjust away for.

18 So I don't have the answer for you at  
19 this time but that's something that we can  
20 definitely bring to the disparity standing  
21 committee for their consideration.

22 CO-CHAIR HANSEN: I think we've ended

1 actually with a request to include this aspect of  
2 the whole issue of discriminatory practices. So  
3 perhaps in the future we can have that be part of  
4 our meetings.

5 So, Megan?

6 MS. ANDERSON: So we have a plan at  
7 this time. So we recognize that you have been  
8 giving us your attention for more than three-and-  
9 a-half hours, and we really appreciate that. We  
10 want to in kind give you 30 minutes and ask you  
11 to come back again with your full attention. And  
12 so you get your full 30-minute lunch.

13 Lunch is for workgroup members and  
14 staff here in support. It is over here. I  
15 didn't have a chance to look at what it is, but  
16 I'm sure it's delicious.

17 And for those from the public who are  
18 in the room, we are happy to give you locations  
19 where you can grab lunch, and you are also  
20 welcome to beverages in the room.

21 So we will reconvene at one o'clock on  
22 the dot. And thank you all so very much.

1                   And while you're getting back settled  
2                   at about 5 minutes to, 10 minutes to, don't  
3                   forget to bring up your Excel spreadsheet and get  
4                   ready to talk about measures. Thanks.

5                   (Whereupon, at 12:28 p.m., the above-  
6                   entitled matter recessed, to reconvene at 1:00  
7                   p.m.)

8                   CO-CHAIR HANSEN: We are going to get  
9                   started right now. And we're moving this first  
10                  part of this presentation. And this will be a  
11                  lot of our lifting of working on the measures and  
12                  getting to know which ones have changed in their  
13                  endorsement, that some of you provided  
14                  opportunity to input on what you considered  
15                  lower priority.

16                  And then there are some newer endorsed  
17                  measures since our last meeting. So Megan will  
18                  kick us off with this presentation.

19                  MS. ANDERSON: Thanks so much.

20                  We have a lot of people that are  
21                  making their way back to their chairs, so I'm  
22                  going to ask everyone to open up their Excel

1       spreadsheets that you received as part of your  
2       materials if you have a computer with you. And  
3       that will be a really helpful resource as we go  
4       through measures that are no longer endorsed.

5               Just to give you a base --

6               MEMBER MONSON: Can I just, a quick  
7       process question.

8               MS. ANDERSON: Yes. Could you use  
9       your microphone.

10              MEMBER MONSON: So is the spreadsheet  
11       the same one that we had commented on originally?

12              MS. ANDERSON: So the question is  
13       whether or not the spreadsheet I am discussing is  
14       the one that was the prioritization exercise you  
15       received in March. The answer to that is no.  
16       They are very similar.

17              This, you should have that out for  
18       reference perhaps, if you filled out that  
19       prioritization exercise, if you want to look back  
20       and reference your own responses. But what I'm  
21       asking you to do is go to either an email that  
22       you received from the MAP Dual's inbox that



1 Janine sent, and go to the SharePoint page or go  
2 to the calendar appointment and get the Excel  
3 sheet from there. You can also download it from  
4 the NQF website and the Dual Beneficiary Project.

5 So the Excel spreadsheet has four  
6 tabs. The first tab is the family of measures  
7 that includes the 76 measures that are currently  
8 endorsed in the family.

9 The next is the newly endorsed  
10 measures that we'll discuss.

11 And the last two are special alternate  
12 measures and cultural competency measures that  
13 help us understand the alternatives to measures  
14 that are no longer endorsed.

15 So please pull up the Excel  
16 spreadsheet that's part of your materials. And  
17 if you have any trouble getting that, please let  
18 us know on staff.

19 So that's an important reference  
20 document. And most of the information will also  
21 be summarized on the slides if you're not as  
22 comfortable with that. It's quite small. But we

1 wanted to make sure you had access to that.

2 So we're going to kind of describe on  
3 slide 73, I'm going to start and kind of describe  
4 the task at hand for this afternoon. It's not a  
5 small task. We have lots of measures and their  
6 applications to consider. And so we want your  
7 input. We'll be using those voting clickers that  
8 we practiced with lunch -- or for dinner earlier  
9 today.

10 So slide 74 describes the six measures  
11 that are no longer NQF endorsed that are  
12 currently in the family of measures. Just before  
13 lunch I described the 76 measures in the family  
14 and what those overall characteristics are. Now  
15 we're going to be looking at the measures that  
16 are no longer endorsed.

17 In doing this, we're going to be  
18 making changes to the family to help maintain its  
19 currency, to maintain it as a current family of  
20 measures. And the question to consider as you  
21 consider these six measures is if you would like  
22 to remove any of the measures from the family.

1 We're going to consider them one by one. Each of  
2 them has a slightly different scenario or  
3 consideration to think about as you make your  
4 decision.

5 Next slide.

6 We're also going to be considering  
7 newly available measures. NQF staff has done  
8 some of the work to help consider and review the  
9 25 newly available measures since this workgroup  
10 last met and reviewed measures.

11 There were 15 measures that were  
12 identified to consider, 14 of which are truly  
13 applicable. But you'll see 15 today. And I will  
14 explain that when it comes to the medication  
15 measures.

16 The remainder of the measures were  
17 determined inappropriate for the population or  
18 really do not address the high leverage  
19 opportunity or gap area.

20 And so we on staff, tried to help make  
21 this a more manageable level of decision making.  
22 And so we'll be looking at 15 newly-endorsed

1 measures today.

2 So the question to consider is would  
3 the workgroup like to add any of these 15  
4 measures that have been newly endorsed to the  
5 family?

6 Would you like to replace any measures  
7 that are in the family? Because what you see  
8 here -- because one of the newly endorsed  
9 measures is far better and better meets the needs  
10 of the population.

11 There are also -- this is a breakdown  
12 of the measures that received endorsement  
13 recently. You will notice that there weren't any  
14 affordability measures, so we don't have any to  
15 consider.

16 While health and well-being is a  
17 priority area for this population from this  
18 workgroup's preferences, we noted that the health  
19 and well-being measures that were newly endorsed  
20 did not address the target population or were not  
21 appropriate.

22 There were four condition-specific

1 measures, and they really do not address any of  
2 the priorities that this workgroup has previously  
3 expressed. We are not presenting them for you to  
4 consider today.

5           There were also two measures that were  
6 limited to children. Again, not appropriate for  
7 the populations that they're -- the population is  
8 made up largely of adults. And we have not  
9 included in the past any measures that are  
10 specific to children.

11           There are also three measures of  
12 prevention treatment for leading causes of  
13 mortality. Again, these are condition-specific  
14 measures that we're not putting to the workgroup  
15 today to consider; they're considered too narrow  
16 for the family.

17           And there are three patient safety  
18 measures. There are two measures of medication  
19 safety, and there is another condition-specific  
20 measure but it's considered too narrow for the  
21 family. It is presented along with these other  
22 two, mostly because it seems fair and seems a

1 little odd to rule out one and the other two will  
2 be presented.

3 There is one measure of effective care  
4 coordination and communication but was  
5 considered, again, too condition-specific and too  
6 narrow for the family.

7 The bulk of your work for measures  
8 that have received endorsement since you last met  
9 is going to be focused at the 3:00 o'clock agenda  
10 item and will take us to the end of the day. And  
11 there it's 12 person- and family-centered care  
12 measures that have been recently endorsed.

13 These measures have been looked at and  
14 really do address priority gap areas that the  
15 workgroup has identified and raised, especially  
16 optimal functioning, as we heard a little bit  
17 earlier today, and person- and family-centered  
18 care.

19 And so I'm going to pause here and see  
20 if there are any questions about what we are  
21 about to embark on.

22 Jim, have you been able to join us on

1 the phone?

2 MEMBER DUNFORD: Hello. Yes.

3 MS. ANDERSON: Thank you.

4 MEMBER DUNFORD: Jim Dunford here.

5 MS. ANDERSON: Are you also on the web  
6 platform?

7 MEMBER DUNFORD: I am.

8 MS. ANDERSON: Great. And so you'll  
9 vote in the chat box?

10 MEMBER DUNFORD: I will.

11 MS. ANDERSON: Thank you.

12 MEMBER DUNFORD: Thank you.

13 MS. ANDERSON: And I wanted to see if  
14 D.E.B. Potter has joined us on the phone.

15 (No response.)

16 MS. ANDERSON: Okay. We're expecting  
17 D.E.B. at some point on the phone. But as a  
18 federal liaison she won't be voting.

19 So everyone will be voting as we  
20 consider these measures for removal or addition  
21 to the family. Have your clicker in your right  
22 hand or your left hand, however you like it, and

1 we'll get started by considering the first  
2 measures that are no longer endorsed.

3 Okay, so next slide. Next.

4 Okay. So the workgroup in 2015  
5 reviewed measure 0007, NCQA Supplemental CAHPS  
6 Measure. It's an adult questionnaire. This  
7 measure was retired by the steward because they  
8 are undertaking substantial revisions onto this  
9 shared decision-making care coordination  
10 questions, which are a priority that this  
11 workgroup has previously expressed.

12 The workgroup previously voted to  
13 retain this measure in the family. And that is  
14 because of the fact that it's going to be  
15 updated. A new version will be submitted but it  
16 is likely still in use while the measure is being  
17 updated. It is like other measures where we've  
18 voted to retain it in the family.

19 The workgroup, however, identified it  
20 as low priority for a vote because it's no longer  
21 endorsed. So we felt it was warranted to bring  
22 it back to the workgroup just to keep you



1 informed of what the workgroup decision was in  
2 2015 and to make sure that that workgroup  
3 decision stands, and whether or not there's any  
4 discussion that the workgroup wants to have about  
5 overturning the 2015 decision, and whether or not  
6 you want to continue to retain it or remove it  
7 from the family.

8 We do not have a specific timeline in  
9 which the new measure would be submitted to NQF  
10 for endorsement, but we understand that it's a  
11 matter of years, not decades.

12 Clarke?

13 MEMBER ROSS: Just an observation. I  
14 believe there are 21 members of the workgroup  
15 eligible to vote in the priority process. You  
16 received 8 out of 21 and on this you actually  
17 received 6 out of 21. So the exercise we went  
18 through is not even representative of our group  
19 sitting here today.

20 So I'd just make that observation when  
21 we consider what the workgroup prioritization  
22 exercise results were.

1 MS. ANDERSON: Very much appreciate  
2 the comment. We do thank the workgroup members  
3 that did provide their prioritization exercise  
4 results. And we understand that many of you have  
5 very busy schedules. And so this piece of  
6 information is, again, provided to inform but not  
7 make the decision. The decision has not yet been  
8 made for anything that has a workgroup  
9 prioritization exercise result.

10 And so, yeah, that's all. Is that  
11 okay?

12 As a note, we have 21 workgroup  
13 members that are eligible to vote. We have 17  
14 that are present for voting. We are missing  
15 three that would be eligible to vote. And so our  
16 -- we did get quorum, however, consensus is 11.  
17 So 11 individuals must vote in one direction or  
18 another to have consensus as we vote.

19 So is there any interest in discussing  
20 removing this measure from the family or is  
21 everyone in agreement that we retain the decision  
22 from 2015 to retain the measure? Any discussion?

1           MEMBER RASK: This is a question. So  
2 this isn't discussion -- is this discussion about  
3 the decision or is it discussion about whether or  
4 not to hold a vote?

5           MS. ANDERSON: We can hold a vote.  
6 Probably it's just clean and cut if we do. But  
7 is there any discussion about overturning the  
8 2015 decision and removing this measure from the  
9 family because it's no longer endorsed?

10          MEMBER RASK: Okay. And I would, I  
11 think that we should consider removing it because  
12 it's no longer endorsed and there isn't a short  
13 time period to expect a replacement. And that's  
14 been since 2015. So I think we should consider  
15 it.

16          MS. ANDERSON: Other thoughts?

17          MEMBER ROSS: So every measure we  
18 consider has methodological weaknesses and has  
19 problems. Like this one says sensitivity to  
20 cultural differences. So I tend to vote for  
21 flawed measures that measure things that are  
22 highly important to me and the Consortium for

1       Citizens with Disabilities.

2               So measures that, and given the lack  
3       of consumer perspective and consumer experience  
4       measures, I tend to continue to support them even  
5       though they're flawed measures. And until we  
6       reach some threshold of meaningful consumer  
7       experience, I will personally continue to vote  
8       for maintaining these and acknowledging their  
9       limit -- that all of our measures are limited and  
10      flawed.

11              So that's just a preamble of how I'm  
12      going to vote on consumer experience of  
13      respective measures. Thank you.

14              CO-CHAIR HANRAHAN: So just to  
15      paraphrase that, you would vote to retain the  
16      2015 decision.

17              Gwen?

18              MEMBER BUHR: I've got a question.  
19      Are there any other measures that measure shared  
20      decision-making?

21              MS. ANDERSON: Answering a different  
22      question, there are other measures of shared

1 decision-making, yes. The advanced care plan  
2 measure that's included in the family, and we'll  
3 also talk about --

4 MEMBER BUHR: Because I think that  
5 might inform the decision. If we have another  
6 measure that's going to cover this one and is  
7 endorsed, then I would vote differently than if  
8 we didn't.

9 MS. ANDERSON: We have several other  
10 experience of care measures, including the ECHO  
11 Survey that's with behavioral health, as well as  
12 other CAHPS measures that are included in the  
13 family. The challenge of shared decision making  
14 measures has been longstanding and there are  
15 measures that touch on it. But it's hard to  
16 measure directly so we have always had that as a  
17 gap.

18 CO-CHAIR HANSEN: Other discussion?  
19 Shall we vote?

20 MS. ANDERSON: And so Option 1 will be  
21 to retain the measure in the family, so it's a  
22 keep. And Option Number 2 will be to -- so if

1       you want to retain the measure in the family you  
2       would vote yes. No. You would vote no. Excuse  
3       me.

4               I apologize. You may remember I was  
5       missing last year. I was dealing with my phone,  
6       so I apologize, it's my first time using the  
7       clickers.

8               So, Janine, do you want to say it?

9               MS. AMIRAULT: Sure.

10              MS. ANDERSON: Thank you.

11              MS. AMIRAULT: So if you're voting to  
12       remove this measure, click 1 for yes. And if you  
13       would like to retain it, 2 for no.

14              (Voting.)

15              MS. AMIRAULT: Okay, looks like  
16       consensus hasn't been reached on this one.

17              MS. ANDERSON: So we need at least 60  
18       percent consensus, and so I think we need to have  
19       some further discussion.

20              Go ahead, Gregg.

21              MEMBER WARSHAW: So maybe we could  
22       just speak to the implications of a non-endorsed

1       measure. What does it mean to be non-endorsed?  
2       And what are the implications of it, of  
3       continuing to have a non-endorsed measure in the  
4       family?

5               MS. ANDERSON: Okay. So we rely on  
6       the consensus involvement process to endorse  
7       measures based on their reliability and validity  
8       and several endorsement criteria. By retaining a  
9       measure that is no longer endorsed, we are not  
10      receiving annual updates and maintenance  
11      information from the steward and the developer.

12             In that there may be changes to a  
13      measure that are needed that aren't being done  
14      and being maintained to specification. By having  
15      this measure we're recognizing that annual update  
16      process is not happening while a new measure is  
17      being -- while the measure is undergoing  
18      substantial revisions.

19             Because it's a CAHPS measure, the  
20      workgroup recognized last year that it was going  
21      to be in continued use across peer study --  
22      excuse me, across populations, despite the fact

1       that it was not going to be endorsed and the  
2       steward was just not using the resources to  
3       maintain endorsement while they were using  
4       resources for development and updates.

5               So I think that the implications are  
6       that we are understanding that there may be  
7       tweaks that could be made to the specifications  
8       that are not being made on an annual basis, but  
9       that the measure has been used for a very long  
10      time, is generally, if not always, has been sound  
11      for a substantial period of time, and that it's  
12      still largely in use.

13              And we have also recognized the  
14      measure selection criteria, that the burden of  
15      measurement is high and stability of measurement  
16      across -- across measures, stability across  
17      measures that is highly valued for end users.

18              Any other questions? Tom?

19              MEMBER LUTZOW: Did the measure  
20      sponsor have an opinion on this?

21              MS. ANDERSON: Because we had them  
22      come last year they shared those thoughts that



1 I'm summarizing last year. And we haven't asked  
2 them to come to this, this meeting today. But  
3 they shared that they will be updating the  
4 measure and that it was largely still in use by  
5 other CAHPS measures. Still in use with other  
6 CAHPS measures.

7 However, Kimberly's point is valid  
8 that we have not yet received an update.

9 Are we ready to call another vote?  
10 Does anyone have any remaining questions? And,  
11 Janine, I'm going to ask you to say it correctly  
12 so I don't make it the wrong vote.

13 MS. AMIRAULT: Okay, so you're voting  
14 -- give me just one moment. It will be 1 to  
15 remove the measure and 2 to retain.

16 (Voting.)

17 MS. AMIRAULT: Okay, so based on the  
18 percentage, the consensus is to remove the  
19 measure.

20 MS. ANDERSON: All right. Thank you  
21 all. That was the easy one.

22 So you may have noticed everyone can

1 kind of take a break for a minute while I -- I'm  
2 trying to keep track of the measures that we're  
3 going to vote on because I think it's important  
4 that that's highly visible. We'll also summarize  
5 these things at the beginning of the morning.

6 Our Senior Vice President is going to  
7 take notes for us. Thank you, Marcia.

8 So, the next slide.

9 The next measure for us to consider is  
10 measure 0054, Medication Reconciliation Post-  
11 Discharge.

12 This measure is no longer being  
13 maintained as an individual measure. We noted  
14 that this measure has been combined with measure  
15 0097, Medication Reconciliation Post-Discharge,  
16 and which is already, and has no change to  
17 endorsement, so it's currently in the family.  
18 And we would expect that would stay in the  
19 family.

20 This is a positive change. It's  
21 harmonization with measures that are similar.  
22 And it's really a great, great process change.

1                   So the measure is the percentage of  
2                   discharges during the 11 months of the measure  
3                   year for patients 66 years old and older that  
4                   were reconciled within 30 days of discharge. The  
5                   workgroup did vote and 4 votes for high priority,  
6                   3 votes for low priority, because an endorsement  
7                   has been removed. And there are three related  
8                   measures of medication management and transitions  
9                   in the family.

10                  So the three related measures are  
11                  0419, Documentation of Current Medications in the  
12                  Medical Records; 0054 -- excuse me, 0554, which  
13                  is the measure under consideration; and 0646,  
14                  Reconciled Measures List Received by Discharged  
15                  Patients.

16                  So the question to the workgroup is  
17                  whether or not this Measure 0054, Medication  
18                  Reconciliation Post-Discharge should be removed  
19                  from the family because it is no longer endorsed  
20                  and maintained as an individual measure, with the  
21                  note that it has been combined with 0097 which is  
22                  in the family, retains the qualities of this

1 measure.

2 Are there any questions or concerns?

3 MEMBER MONSON: So when you say it's  
4 been retained, without getting into each one, is  
5 it fully contained so the entire essence of the  
6 question is embedded in the other questions? So  
7 if we get rid of it we don't lose anything?

8 MS. ANDERSON: Right.

9 MEMBER MONSON: Thank you.

10 MS. ANDERSON: You lose a number.

11 MEMBER MONSON: Well.

12 MS. ANDERSON: Which is nice.

13 Any other questions or concerns?

14 Seeing none, Jim, any questions? So we are going

15 --

16 MEMBER DUNFORD: No. No, my same  
17 question as before. It sounds like it's included  
18 in the new measure. Thanks.

19 MS. AMIRAULT: Okay. So 1 for removal  
20 and 2 for retaining.

21 (Voting.)

22 MS. AMIRAULT: If everyone wouldn't

1 mind just pointing one more time and casting  
2 their vote. Thank you.

3 And just one more time. Sorry.

4 MS. ANDERSON: I think we may have  
5 gotten the -- so we're moving the measure.  
6 Fantastic.

7 Okay. Thank you all for your  
8 patience. I'm sorry we didn't see him step out.

9 We're going to move on to the next  
10 slide where we're going to consider measure 0692,  
11 Consumer Assessment of Health Providers and  
12 Systems, Nursing Home Survey: Long Stay Resident  
13 Instrument.

14 This measure was not included in the  
15 exercise materials. Important to note. So the  
16 prioritization exercise in March, this team  
17 should not occur in that, your set of materials.  
18 So it did occur and was represented in materials  
19 received last workgroup meeting.

20 The steward is no longer maintaining  
21 this measure and maintaining performance measures  
22 derived from survey items. It is part of the

1 field evolution. And as we learn and grow as a  
2 field together to understand the difference  
3 between surveys and measures.

4 So the instrument is not being  
5 endorsed anymore. It includes five topics on  
6 environment, care, communication and respect,  
7 autonomy and activities, and provided nursing  
8 level -- nursing home level scores on three  
9 global items.

10 While it was voted high priority by 6  
11 measures, it was because the quality of care is  
12 important and varies, but it also is really  
13 important to consumers.

14 Now, the preliminary analysis is to  
15 remove the measure and consider addition of  
16 newly-endorsed measures that address priorities  
17 in person- and family-centered care, which we're  
18 going to review this afternoon, but which is on  
19 there as well.

20 And so I think it's important to  
21 recognize here that we have other CAHPS measures  
22 in the family that are measures based off of

1 survey items. However, this measure is not truly  
2 a measure that is NQF endorsable and so it is  
3 more really an instrument. And so it is no  
4 longer being maintained by the steward.

5 And I'm going -- happy to take  
6 questions. So Joan goes first.

7 MEMBER ZLOTNIK: So I understand that  
8 it's no longer endorsed and there is this  
9 question of whether it's a measure or not.  
10 However, considering that of the eight people who  
11 did the exercise, six of them saw this as a high  
12 priority. And it addresses critical issues  
13 related to nursing home residents.

14 I'm wary of removing it without  
15 actually seeing what those other measures are and  
16 whether they actually encapsulate some of the  
17 absolute missing elements of most nursing home  
18 care in the U.S., like communication, respect and  
19 autonomy. So it's a hard decision to make  
20 because I don't feel like I have enough  
21 information to actually do it.

22 MS. ANDERSON: Unfortunately, I think

1 the lack of endorsement of alternative measures  
2 that I can offer you to consider to replace this  
3 measure is reflective of our priority CAHPS list.  
4 And while the measures of person- and family-  
5 centered care are -- make progress on functional  
6 status, they do not focus on these elements as  
7 specifically as I think you are looking for.

8 And so I don't have alternatives to  
9 offer, although I looked.

10 CO-CHAIR HANRAHAN: My understanding  
11 is then, if a measure is not -- if there's not a  
12 steward, the steward isn't maintaining the  
13 measure then that measure has to go. Is that  
14 basically how it goes?

15 MS. ANDERSON: It's no longer going to  
16 be valid and reliable. It's really hard to make  
17 a recommendation to CMS to use it.

18 MEMBER STUART: But then the question  
19 becomes these are, you know, five important value  
20 areas. And if we simply drop it because there is  
21 no steward, we're dropping some of these aspects  
22 of care.



1 MS. ANDERSON: So I think it's  
2 important to note that the steward is recognizing  
3 the measurement science behind this and that it's  
4 an important instrument that -- while the CAHPS  
5 surveys are still in use, that this does not  
6 result in a valid, reliable, NQF endorsable  
7 measure.

8 And one recommendation that I haven't  
9 quite heard but I'm hearing inklings of is that  
10 there should be a valid and reliable, NQF  
11 endorsable measure based on these concepts. And  
12 so that could be a recommendation if the  
13 workgroup chose to develop that.

14 MEMBER ROSS: I believe a number of  
15 states are using this measure currently. It  
16 takes states a long time to adopt a measure and  
17 then it takes them some time to replace them. So  
18 I guess my thinking is this addresses some very  
19 important aspects that are valued by residents.  
20 It's a resident-value measure and states are  
21 using it, despite the status of the measure's  
22 steward.

1                   So I'm going to continue to retain  
2                   this one. If states collectively drop it because  
3                   of the National Quality Forum and they can  
4                   replace it with something better, that's another  
5                   topic for another day.

6                   CO-CHAIR HANRAHAN: You know, I see  
7                   this process as being housekeeping process. So  
8                   if NQF says that this is not a valid measure  
9                   because it doesn't meet the requirements that are  
10                  established around science validity, then it  
11                  seems -- and so they're recommending that we not  
12                  endorse this measure, despite the fact that this  
13                  measure is measuring concepts that we would like  
14                  to have measured, could we not endorse this  
15                  measure but recommend that another measure be  
16                  developed that has these concepts that make it a  
17                  valid measure?

18                  MEMBER ROSS: Then it becomes a gap  
19                  area. And I think we should recognize the board  
20                  and leadership of the National Quality Forum  
21                  wants to reduce measures because they're being  
22                  criticized by providers and plans and us and

1 other people that there are too many measures.  
2 And I don't want to be part of the dynamic -- the  
3 meeting was successful because we eliminated x  
4 number. I don't want the other side to say the  
5 meeting was successful because we added 25, or  
6 whatever the number is.

7 But there is this pressure to reduce,  
8 reduce, take away. And I'm okay if it's a  
9 replacement. But to say for a measure to be  
10 developed in the future means it's a gap, these  
11 areas that states require now will become a gap  
12 area in the way of classification at the National  
13 Quality Forum in my view, so.

14 MS. ANDERSON: Marcia?

15 DR. WILSON: I'll just make a brief  
16 comment.

17 The discussion we're having here plays  
18 out in almost every committee meeting that we  
19 have. And I don't have a simple answer for you.  
20 I am going to leave it to the wisdom of the  
21 committee to decide. And the conversation that  
22 we often have here is much like one we're hearing now.

1           For example, we have a process measure  
2       that's been in use for a long time. It does not  
3       -- the steward may elect not to continue the  
4       endorsement or it may not have the endorsement  
5       maintained. And the complaint that you hear is  
6       if this measure is gone does it mean we are not  
7       going to pay attention to those important issues.

8           And so I don't know if that's any help  
9       at all. But this is the conundrum that you're  
10      talking about, Clarke, is one that's connected.  
11      I would not want the committee to feel pressure  
12      in terms of, oh, we must reduce some measures.  
13      That was definitely not the mandate that we are  
14      giving you. That is not the charge to the  
15      committee.

16           I think the consideration, as Megan  
17      has said, is that this measure will no longer  
18      stand for reasons, for certain reasons. And,  
19      yes, you're right, if endorsement is moved then  
20      it does create a gap that the committee  
21      identifies as a gap area for future development.  
22      And this is a challenging issue because now, now

1 we have to wait for that gap to get filled, and  
2 we want that gap to be filled.

3 So I'm just saying this conversation,  
4 we have heard this conversation before and we  
5 leave it to the individual committees to  
6 determine whether they keep something before them  
7 because they feel like it identifies an important  
8 area or they decide not to keep that measure and  
9 identify where they want the measure developers  
10 to go.

11 MEMBER DUNFORD: Hi, this is Jim. I  
12 just don't want perfect to be the enemy of good.  
13 And so that's the concept I think that Clarke is  
14 also alluding to is what I'd like to know from a  
15 practical term is when would the next best be  
16 available?

17 MS. ANDERSON: I don't have that kind  
18 of information. I think we heard from CMS some  
19 really promising information earlier this morning  
20 about how they have contracts for development of  
21 six new measures for low beneficiaries and 12  
22 measures for Medicaid beneficiaries. However, we

1 are not privy to the titles and specifications of  
2 those measures at this time.

3 MEMBER MONSON: So I ask this at the  
4 humility of being a new member of the group, but  
5 is there a way for us, you know, like on the  
6 stars measures there's display measures and  
7 there's measures that count. Is there a way for  
8 us to keep this as one that would -- we are  
9 basically saying we think it's valuable. Right?  
10 We understand that there's limitations in the  
11 science but we don't want to just discard it, so  
12 we can put it off into another bucket.

13 Is that an option or that -- is this  
14 an either/or?

15 MS. ANDERSON: There is a way to  
16 reemphasize and the gap area that this instrument  
17 leaves, the void that it leaves, to provide a  
18 description of that and to encourage development  
19 of a measure. There is somewhat a yes/no answer  
20 that needs to be made of is this measure in the  
21 family or not?

22 However, in the case of CAHPS

1 measures, the workgroup has previously generally  
2 supported the use of experience of care and any  
3 question of that type of data. And so CAHPS  
4 instruments, surveys, tools, measures generally  
5 has been largely supported.

6 So you could express continued support  
7 for use of CAHPS generally while this instrument  
8 is continuing to be used in nursing homes. It is  
9 no longer -- it is not a valid and reliable  
10 measure, therefore it does not belong in the  
11 family as a measure. So there could be a  
12 distinction for support of CAHPS generally but  
13 remove the measure because it's not endorsable.

14 It is a conceptual challenge. And I  
15 didn't start with this one because it wasn't the  
16 easy one. Okay? Does that help?

17 CO-CHAIR HANSEN: I think this is kind  
18 of the prototype of the example of the conflicts  
19 that we're going to continue to face because of  
20 the nature of the content is stuff that is  
21 already identified in our gap area. But then  
22 there is the methodological issue going on.

1           So as you were saying that this is  
2           going on in other areas, and so I think, Michael,  
3           your suggestion and the ability perhaps to, for  
4           the Coordinating Committee to take this into  
5           consideration.

6           MS. ANDERSON: Go ahead.

7           MEMBER RASK: I understand the  
8           conundrum that we're in is balancing that we  
9           don't want, you know, good is not the enemy, if  
10          it's all we have. But the other thing I think is  
11          we have the one thing that NQF has a role as is  
12          we're kind of a good housekeeping seal of  
13          approval. And if we don't include the measure in  
14          the family it doesn't disappear. But if we do  
15          include it in the family then we're saying if you  
16          use this tool it's valid, reliable, and you newer  
17          doctors ought to consider adopting it.

18          And that's the part that concerns me  
19          because I'm happy, and I think anyone who is  
20          currently using it and wanting to continue and  
21          not wanting to change their program, probably  
22          that's what they're going to do. But what I



1 would hate is for someone to come and look at it  
2 and say I'm looking at a new measurement. This  
3 must be a good one, it's being listed here.

4 So that's where I recognize this and  
5 so I kind of lean more towards saying I don't  
6 want to give it that good housekeeping seal of  
7 approval, I do want to make it clear that, you  
8 know, note in our gaps that we need more good  
9 measures like this, and this measure is out  
10 there. But we can't really hold it up as one of  
11 the best.

12 MS. ANDERSON: Joan.

13 MEMBER ZLOTNIK: I guess the problem  
14 is the voting process. So if I could vote and  
15 say, yes, you could remove this but and have that  
16 right there, then it works for the reasons that  
17 Jim and other people have talked about. But by  
18 just voting on it without that is a very hard  
19 process.

20 So if we can vote kind of with an  
21 asterisk and do it that way, it becomes very  
22 different than just voting it out.

1 MS. ANDERSON: Okay. I'm going to ask  
2 you what that but would be but I'm also going to  
3 make sure that Tom gets to share his thoughts.

4 MEMBER DUNFORD: Yeah. I have never  
5 met a measure that doesn't capture a value and a  
6 good. On the other hand, if a measure does an  
7 imperfect job, an invalid job of measuring the  
8 good, then I can't support it. That doesn't mean  
9 I dismiss the good.

10 My concern generally with CAHPS -- and  
11 I know it's gotten criticism, it's not translated  
12 into Hmong, it's not translated into Russian, and  
13 so I think there's a Spanish translation and an  
14 English version and so on and that's the limit of  
15 it -- we have evidence with CAHPS, and to me it's  
16 not going to dismiss the value, it's very  
17 valuable, but we sent out a survey outside the  
18 CAHPS survey period that was pretty much  
19 identical to the gap survey. And got it back and  
20 were sort of surprised at the results there.

21 There were a number of ones that were  
22 circled by some of our members. And we went back

1 to the member and said, Why did you circle number  
2 one on this?

3 Because you're number one.

4 No, see we're number ten if you think  
5 we're number one.

6 And I do think that there's probably  
7 a lack of clarity in we don't make the right  
8 assumptions about literacy levels and that sort  
9 of thing in that survey. And someone needs to  
10 pay closer attention to that, to that instrument  
11 and what's coming back through it.

12 MS. ANDERSON: So I don't see any  
13 other cards up.

14 Joan, would you like to propose a  
15 "but," remove the measure and other, other things  
16 to vote on?

17 MEMBER ZLOTNIK: I guess I would say  
18 that the MAP Committee voted to remove the  
19 measure for the fact that it's no longer endorsed  
20 and there are issues with it. However, the  
21 topics valued by residents in terms of  
22 environment, care and communication, respect,

1       autonomy and activities, particularly related to  
2       nursing home residents, are critically important  
3       issues for dual eligible populations,  
4       particularly those in residential programs.

5               And I want to highlight that as a  
6       critical need for available measures, or some  
7       such thing.

8               MS. ANDERSON: Thank you for making my  
9       report writing easier.

10              MEMBER ZLOTNIK: Spent a lot of years  
11       writing reports.

12              MS. ANDERSON: So we are going to be  
13       voting to remove the measure but emphasizing that  
14       topics valued by residents are critically  
15       important for issues for the population and need  
16       to be reflected.

17              MS. AMIRAULT: Okay. So vote --

18              CO-CHAIR HANRAHAN: Is everybody clear  
19       about what we're voting?

20              MEMBER ROSS: So if we vote no, we're  
21       endorsing Joan's additional --

22              CO-CHAIR HANRAHAN: No, that's if we

1 vote yes we are saying remove the measure but.

2 If we vote no, we're saying, no, keep the

3 measure.

4 MS. AMIRAULT: Okay. So, again,  
5 voting for 0692 for removal from family of  
6 measures, one being yes removed, and two being  
7 no.

8 (Vote.)

9 MS. AMIRAULT: Okay, we're just going  
10 to vote once more for 0692 for removal for family  
11 of measures; one being yes, removed, and two  
12 being no.

13 (Voting continues.)

14 MS. AMIRAULT: Okay, so 15 for yes,  
15 remove; and zero no. So 100 percent.

16 MS. ANDERSON: Thank you. And sorry  
17 about that technical glitch.

18 We're going to move on to Measure  
19 1902, Clinician's/Groups' Health Literacy  
20 Practices based on CAHPS Item Set for Addressing  
21 Health Literacy.

22 This measure, the conditions around

1       this measure are largely similar to the measure  
2       we just discussed and so this measure is no  
3       longer endorsed. Again, this measure was not --  
4       the endorsement, our removal was not included in  
5       your exercise you received in March but it was  
6       included in the materials you received last week.

7               It's an item domain set communication  
8       with provider, disease self-management,  
9       communication about medicines, communications  
10      about test results, and communication about  
11      forms.

12              The steward is no longer maintaining  
13      performance measures derived from the survey  
14      items. Again, it is a survey and it is not NQF-  
15      endorsable measures.

16              The workgroup, again prioritization  
17      exercise results again provided some priority for  
18      the health literacy issue. And self-analysis,  
19      preliminary analysis is to remove the measure and  
20      consider addition of newly-endorsed measures for  
21      person- and family-centered care.

22              We can open it up for discussion.

1 CO-CHAIR HANRAHAN: And perhaps, Joan,  
2 if you may want to propose a similar type of vote  
3 after you're heard some discussion.

4 Any questions about this measure and  
5 retainment or removal of this measure from the  
6 family?

7 MEMBER ZLOTNIK: So I guess I have the  
8 same issue about health literacy is one aspect of  
9 patient- and family-centered care, and so we're  
10 in the same dilemma here I think that we were  
11 with the last one. So I would endorse the "but"  
12 suggestion.

13 MS. ANDERSON: Go ahead, Joan.

14 MEMBER ZLOTNIK: And I think Tom  
15 actually just spoke to it in the last piece in  
16 terms of talking about different populations for  
17 whom the measures sort of are not available or  
18 there's translators not available or is there  
19 lack of understanding, communication between  
20 providers and patients. So once again, it's a  
21 very critical issue. You know, is it always on  
22 those lists of things that are important?

1                   So I've come up with a question, Do  
2                   any of the person- and family-centered care  
3                   measures like we're going to talk about later  
4                   actually also address this? Because if you just  
5                   say, yes, you know, Measure 2172 perfectly  
6                   addresses it, then it's easier to say no.  
7                   Otherwise I feel like we have to say -- I mean  
8                   yes, whatever the answer is -- yes, removal,  
9                   otherwise I'd be need to say "yes but."

10                  MS. ANDERSON: I have no alternative  
11                  health literacy measures to offer you for  
12                  consideration.

13                  Are we ready to go to a vote?

14                  MS. AMIRAULT: Okay, so for Measure  
15                  1902 for removal from family measures, one being  
16                  yes remove, two being no.

17                  MS. ANDERSON: With a caveat. And the  
18                  caveat is topics valued by residents and that are  
19                  in this measure and are critically important  
20                  issues for the population but not reflected in  
21                  the current family of measures.

22                  (Vote.)



1 MS. AMIRAULT: Okay. So for Measure  
2 1902 for removal from family of measures, 15  
3 saying yes, remove, and one saying no.

4 MS. ANDERSON: Thank you.

5 We're going to move on to Measure  
6 1909, Medical Home System Survey.

7 This measure has had endorsement  
8 removed and the developer has withdrawn this  
9 measure and is presently no longer able to  
10 support it.

11 The measure Medical Home System Survey  
12 assesses the degree to which an individual  
13 primary care practice or provider has in place  
14 the structures and processes of an evidence-based  
15 patient-centered medical home.

16 The survey is composed of six  
17 composites that address particular domains:  
18 patient-centered access, team-based care,  
19 population of management, care management and  
20 support, care coordination and care transitions,  
21 performance measurement and quality improvement.

22 The workgroup prioritization results

1 were split: 3 votes for high priority to support  
2 innovative care, is some of the rationale; and  
3 also 3 votes for low priority, not endorsed.  
4 It's a complex measure to use, so there's  
5 provider burden, and also a limited focus, and  
6 reasonably could be measured in other ways  
7 whether or not there's evidence-based patient-  
8 centered medical home.

9 The preliminary analysis from staff is  
10 to remove the measure although there are no  
11 alternatives available, and to continue use of  
12 0005, CAHPS Clinician-based measure, and  
13 development of a patient-reported outcome and  
14 experience of care performance measures that are  
15 priority gap areas.

16 Are there any questions or discussions  
17 on this measure?

18 CO-CHAIR HANRAHAN: Joan?

19 MEMBER ZLOTNIK: This is really a  
20 clarifying point. Are these some of the same  
21 measures that we selected because they filled  
22 gaps that otherwise weren't addressed, even

1       though they were not perfect measures? And so  
2       they end up being sort of the sketchiest measures  
3       because they're so hard to measure.

4               So it's I'm just a little concerned  
5       that we're kind of undoing our own work in a way.

6               MS. ANDERSON: We're not considering  
7       any changes to the family of 76 measures which is  
8       generally so large because there are only five  
9       priority areas. So we have 76 measures to  
10      address five priority areas. So there is  
11      definitely the workgroup has made efforts to try  
12      to get at those priority areas from different  
13      angles with measures that do address them from  
14      different settings analysis or differently.

15              And this is one measure that is no  
16      longer being maintained by the developer and so  
17      endorsement has been removed. And so if we --  
18      you know, there is an alternative, the CAHPS  
19      measure that is currently endorsed.

20              It is an endorsable measure, it is not  
21      one of those measures that's going to be removed  
22      because it's just an instrument.

1           So I would say that, you know, that's  
2   what I recall and supporting what you're also  
3   recalling. And it's for the workgroup to discuss  
4   whether or not they want to remove this measure  
5   from the family.

6           MEMBER LAKIN: Just a quick question.  
7   A lot of these so-called measures that we've been  
8   looking at, the last three or four, really strike  
9   me as instruments with embedded perhaps composite  
10   measures. And I've always been told that NQF  
11   doesn't endorse instruments, it endorses  
12   measures. And I'm failing to see the  
13   distinction.

14           And if there isn't a distinction,  
15   should these composites that are making up the --  
16   I'll call it an instrument because it's more than  
17   a measure -- should they be looked at  
18   individually or is that a can of worms you don't  
19   want to get into? But at the same time there's  
20   some awfully good instruments out there that  
21   we've been told flat out you can't, you can't  
22   bring forward because NQF doesn't look at

1 instruments.

2 DR. MUKHERJEE: So I will attempt at  
3 answering this question.

4 So, yes, it has been an evolving field  
5 and decision. And NQF does not endorse  
6 instruments, we endorse measures that are built  
7 on elements from the instrument.

8 So if somebody interpreting an  
9 instrument bought all the 40 different measures  
10 from that as single, separate endorsement  
11 measures, potentially we would go through them,  
12 through the process. But I think what we're  
13 trying to get is, is that validity and evidence  
14 and sort of the scientific validity of the  
15 measure and trying to see, you know, trying to  
16 parse it out when you were looking at a whole  
17 measure.

18 You know, a patient-reported outcome,  
19 How do you feel today? is different from a  
20 measure that has maybe six or seven different  
21 questions and then developing a measure from that  
22 is one level further to get at a certain

1 percentage of patients feel better, you know,  
2 when they're on this med. And then you ask this  
3 question or they are provided the surveys in  
4 their home settings.

5 So we're really trying to get at the  
6 true validity of what we're asking. And  
7 methodologically it's difficult to do when you  
8 have a measure that can have questions that get  
9 to different elements, which is why we need to  
10 look at the elements separately as a performance  
11 measure.

12 So an instrument is a PROM, a patient-  
13 reported outcome is a PRO, and a PRO/PM is a  
14 performance measure based on a question  
15 instrument.

16 And some of these are older measures.  
17 So if something like a CAHPS 0007 was voted in  
18 four years ago, the field has been evolving since  
19 then. So at this point if it came up for  
20 discussion it would be a different discussion  
21 than probably five years ago. So as the field is  
22 evolving, as we see more instruments, as the

1 instruments are becoming more complex and more  
2 composite-like, we're having to sort of change  
3 the methodology and how we adjudicate the  
4 scientific validity and the level of evidence for  
5 them.

6 And I'll see if Elisa wanted to add  
7 anything to that.

8 MS. MUNTHALI: So Debjani is right.  
9 And so also when we're looking at composites  
10 we're looking at how, we're assessing how the  
11 composites are structured and the rationale for  
12 pulling them together; they have a single score.

13 In the past, many years ago, and  
14 Debjani is right about the historical context of  
15 these measures, we did endorse instruments. But  
16 we have since changed our policy. So that's why  
17 you see some of this confusion between what used  
18 to happen in the past and what our current policy  
19 is now.

20 MEMBER DUNFORD: Hi, this is Jim  
21 Dunford from San Diego. I think in my own  
22 understanding of, you know, it is helpful if you

1 can provide that level of granularity. I mean at  
2 the end of the day my question is why did the  
3 measure steward decide to no longer endorse the  
4 measure?

5 And so just providing a little bit  
6 more context for me would be helpful to  
7 understand exactly why they decided this  
8 longstanding measure wasn't really fit anymore.  
9 That would help me decide how I'm going to vote  
10 on each of these things.

11 MS. ANDERSON: I don't have  
12 granularity unfortunately. But the measure, the  
13 steward was no longer able to support the  
14 endorsement of this measure.

15 And I know we also work with stewards  
16 trying to find an alternative steward that could  
17 support it and to make sure that their job is  
18 feasible. But it is still important that they  
19 submit data that supports the validity and the  
20 reliability of the measure ongoing as the  
21 populations continue to change.

22 CO-CHAIR HANRAHAN: Mady.



1                   MEMBER CHALK: So going along with  
2 these questions, are there -- it would be helpful  
3 to have some background about whether there is  
4 any other -- Joan raised the question -- medical  
5 home measure that is patient-centered in the  
6 sense that this is asking whether, whether a  
7 practice or a provider has the structures. It  
8 isn't patient-centered. This is not patient-  
9 centered.

10                   Practice or provider has structures in  
11 place to be able to support a patient-centered  
12 medical home. It's not like you could never find  
13 that out. It's not unfindable. Is there  
14 anything that exists such that we don't have to  
15 care about this anymore?

16                   MS. ANDERSON: The only alternative  
17 I've been able to find off the queue is CAHPS  
18 0005.

19                   MEMBER CHALK: Which is?

20                   MS. ANDERSON: Which I can read the  
21 measure description. It's also available on line  
22 number 3 of your Excel spreadsheet.

1 I can also offer that, as I said,  
2 there are many certification -- not many -- there  
3 are certification programs now for patient-  
4 centered medical homes as well, so certification  
5 programs.

6 CAHPS 0005, the Consumer Assessment  
7 Healthcare Provider and System Clinician Group  
8 Survey is a standardized survey instrument that  
9 asks patients to report on their experiences with  
10 primary and specialty care received from  
11 providers and their staff in ambulatory care  
12 settings over the preceding 12 months.

13 And so there are questions for adults  
14 and children. And all the questionnaires can be  
15 used in both primary settings and specialty care.  
16 And the adult survey is administered to patients  
17 18 and older.

18 Any exclusions include patients that  
19 had another member of their household already  
20 sampled and patients who are institutionalized.  
21 And it is risk-adjusted at the level of analysis  
22 of clinician. And it's a data sources patient

1 survey and it's an ambulatory care setting only.

2 It is used in several federal  
3 programs, and including the CMMI, the shared --  
4 Medicare Shared Savings Program for ACOs, CMF  
5 meaningful use for eligible professionals, PQRS,  
6 the Physician-Based Value Modifier. And it's a  
7 CMS core measure set for ACOs, TCMH and primary  
8 care measures.

9 So any other questions?

10 CO-CHAIR HANRAHAN: Kimberly.

11 MEMBER RASK: And I would say just  
12 from some use of that, with that tool there are  
13 questions about how your physician spoke with  
14 you, how the nurses treated you, were you able to  
15 get after-hours care, were you able to get care  
16 when you needed.

17 So I think it really does address many  
18 of the concepts that would be important to  
19 patients. And the other version is well-  
20 accepted. And as you pointed out it's being used  
21 by, you know, all of the payment programs that  
22 are focused around care coordination. So I think

1 it does grab at that.

2 CO-CHAIR HANRAHAN: Michael.

3 MEMBER MONSON: So I agree with things  
4 that are being said about CAHPS. The one thing  
5 which I think is important, maybe it's echoing  
6 what Tom was saying earlier, is that there is,  
7 there is some challenge at the top box  
8 methodology, especially with this population. I  
9 think the TEP work has shown that there may not  
10 be complete understanding of how you're voting  
11 and what it means. And if it's top box only -- I  
12 mean I don't know if we're getting into CAHPS  
13 here -- but I just do want to point out that  
14 there are challenges with CAHPS that we need to  
15 be aware of when we're talking about this  
16 population and thinking about how to better  
17 demonstrate the issues.

18 CO-CHAIR HANRAHAN: My question is so  
19 what does NQF require of the stewards in order to  
20 provide valid evidence that the instrument or the  
21 measure is working?

22 MS. MUNTHALI: So what we want to make

1       sure is that the quality, quantity and  
2       consistency of the evidence is there. So we are  
3       looking for a scientific review of the evidence  
4       in terms of studies. We want to make sure that  
5       there are at least five of them and that  
6       directionally the evidence is going in the same  
7       direction.

8               So it's pretty high rigor of evidence  
9       that the steward has to demonstrate in order to  
10      pass. This is a must pass criterion. So if a  
11      measure is evaluated on evidence and that's the  
12      first sub-criterion within inquiries to measure  
13      and report, if they are evaluated on that and  
14      they fail, the measure does not prevail and the  
15      measure is not endorsed.

16             CO-CHAIR HANRAHAN: I think what I'm  
17      hearing is that perhaps some of these populations  
18      and these configurations of where we're getting  
19      the data, we may not get that level of rigor.

20             MS. MUNTHALI: We have an exception,  
21      especially in fields in which there may be  
22      significant gaps. There may not be the studies

1       there to really base the measure on.

2               We do have an exception to the  
3       evidence that the committee can evoke. And so as  
4       a reminder, these are experts like yourself that  
5       sit on these different subject matter committees.  
6       And so they know what's out there, what's not out  
7       there. So they can vote to say that there, in  
8       the absence of the evidence of the rigor that  
9       we're asking for, they can have an exception to  
10      that. And the measure then goes on to the next  
11      criterion. And the next criterion is looking at  
12      the opportunities for improvement.

13              CO-CHAIR HANRAHAN: Aline.

14              MEMBER HOLMES: I'm just asking NCQA  
15      does have patients that are medical home  
16      certification process. They have standards and  
17      guidelines. Wouldn't that be an acceptable  
18      augmentation for this, or I mean alternative to  
19      this? Because they do have a whole website with  
20      all kind of resources and certification. And  
21      this is nationally recognized. I know CMS  
22      reimburses, at least has some practice doing

1       that, using them.

2                   MS. ANDERSON: We have discussed the  
3       importance of patient-centered medical homes with  
4       this workgroup.

5                   MEMBER HOLMES: I can't hear you.

6                   MS. ANDERSON: We have discussed the  
7       importance of person- and patient-centered  
8       medical homes previously with this workgroup and  
9       they've largely been supported as one of the  
10      strategies that can address quality improvement  
11      and support quality improvement for the  
12      population. However, I don't have any measures  
13      to offer you as alternatives of patient-centered  
14      medical home demonstration at the primary care  
15      practice or provider level outside of 0005.

16                   So there are certification programs in  
17      place. And we could revisit that at a future  
18      date. But we don't have certification programs  
19      that we've necessarily included in the family, is  
20      the word. That wouldn't really be the -- it's  
21      more focused on measures.

22                   CO-CHAIR HANRAHAN: Any other

1 discussion?

2 (No response.)

3 CO-CHAIR HANRAHAN: We're ready to  
4 vote.

5 MS. AMIRAULT: Okay. So for Measure  
6 1909, voting for removal from family of measures,  
7 one being yes, and two being no.

8 (Vote.)

9 MS. AMIRAULT: Okay, 14 for yes,  
10 remove; 3 for no. 82 percent for removal from  
11 the family.

12 MS. ANDERSON: Thank you.

13 The next measure to consider is a  
14 little bit of a twist, an exciting twist. The  
15 Measure 0201, Pressure Ulcer Prevalence, Hospital  
16 Acquired, is -- has endorsement removed because  
17 the steward is no longer maintaining the measure.

18 This measure has available  
19 alternatives to consider. That's the exciting  
20 twist, if you missed it.

21 So the total number of patients that  
22 have had hospital-acquired nosocomial infections



1 of category Stage 2 or greater pressure ulcers on  
2 the day of the prevalence measurement. It's a  
3 risk adjustment outcome measure. And it's  
4 specified for hospitals and PAC/LTC settings.

5 And four members of the workgroup  
6 voted that this was a high priority measure.  
7 Could be important for screening measure, and  
8 pressure ulcers are an important clinical  
9 condition that can lead to institution and spread  
10 of severity and disability.

11 Two members voted that it was a low  
12 priority measure on the spirit of parsimony and  
13 because the endorsement has been removed.

14 Staff preliminary analysis is to  
15 remove the measure and consider available  
16 alternatives.

17 Would anyone like to discuss this  
18 measure before we consider available  
19 alternatives?

20 CO-CHAIR HANRAHAN: Yes, Clarke.

21 MEMBER ROSS: This is an example of an  
22 inadequate measure that some of us supported a

1        few years ago because of the importance of  
2        screening for pressure ulcers. Christopher Reeve  
3        died with infection of a pressure ulcer. And he  
4        had around 24-hour expert care and still didn't  
5        detect the pressure ulcer.

6                So many of these measures are for one  
7        setting and one population group and one time  
8        period which on the base of it's just not  
9        adequate. And yet where are the alternatives?

10               So I know there is a home health  
11       pressure ulcer measure because the home health  
12       providers on the PAC Long-Term Care voted against  
13       it because they didn't think it was worth it.  
14       Think it's only 6 percent of their clientele have  
15       pressure ulcers.

16               So my question is how many pressure  
17       ulcer measures are National Quality Forum  
18       endorsed? And what settings do they cover?

19               MS. ANDERSON: We will consider those  
20       in the next slide.

21               Any questions about 0201? Aline, is  
22       your card up or is that from before?

1 CO-CHAIR HANRAHAN: Megan, did you  
2 answer Clarke's question?

3 MS. ANDERSON: There are five measures  
4 in the next slide to pressure ulcers. Five  
5 measures to pressure ulcer on this slide. And  
6 we're on slide 84. And there is one measure on  
7 0531, Patient Safety for Selected Indicators,  
8 which includes a component with pressure ulcers.

9 1789, Hospital-Wide All-Cause  
10 Unplanned Readmission. It is currently in the  
11 family but it is All-Cause Unplanned Readmission,  
12 even though there's not a focus on pressure  
13 ulcers, that I'd like for the workgroup to  
14 consider. That we're putting forward for you to  
15 consider, whether or not you like it.

16 And there is 0679, Percent of High  
17 Risk Residents with pressure ulcers.

18 And 0678, Percent of Residents or  
19 Patients with Pressure Ulcers That Are New or  
20 Worsened, a short-care nursing home care measure.

21 And 0538, Pressure Ulcer Prevention  
22 Care which is a measure that's on reserve status

1 because there was a high performance across the  
2 population.

3 So these measures will be presented at  
4 this session for you to consider. And I can go  
5 forward with that at this time if there are no  
6 questions. Okay.

7 CO-CHAIR HANRAHAN: Thank you, Megan.  
8 That was great.

9 So we should go back and do a vote on  
10 the other one.

11 MS. ANDERSON: I'm getting the sense  
12 that the workgroup would like to consider the  
13 alternatives before voting to remove the measure  
14 that's no longer endorsed. Okay.

15 Should I go forward?

16 CO-CHAIR HANRAHAN: Oh, sure.

17 MS. ANDERSON: Okay, let's go to the  
18 next slide.

19 0531, Patient Safety for Selected  
20 Indicators. This is a modified version of the  
21 PSI90. This is a staff pick. And I will go  
22 through specifically why this measure rose to the

1 staff pick category.

2 This is a Patient Safety for Selected  
3 Indicators. It's a weighted average and  
4 reliability-adjusted, indirect standardized,  
5 observed-to-expected ratios for some indicators.  
6 It includes PSI03, Pressure Ulcer Rate, among  
7 others.

8 It's a risk-adjusted composite  
9 measure. And this workgroup has previously  
10 expressed preference for composite measures,  
11 measures that collectively represent quality with  
12 more than one element as opposed to individual  
13 measures because of burden.

14 It's also a measure of hospital and  
15 acute care. And you'll recall 0201 is a  
16 hospital-based measure. So this measure directly  
17 addresses the gap that that measure leaves.

18 It's also currently in use in hospital  
19 in-patient quality reporting and hospital value-  
20 based reporting programs. So this measure is in  
21 use currently in federal programs, which reduces  
22 the burden of additional measures.

1                   So the staff analysis is to consider  
2                   this as an alternative to 0201, Pressure Ulcer  
3                   Prevalence, Hospital Acquired, because it's a  
4                   hospital and facility based measure and used in  
5                   several programs and addresses a wide range of  
6                   safety issues relevant for the population.

7                   Any questions?

8                   MEMBER MONSON: So I was just taking  
9                   a look quickly through them and I just want to  
10                  make sure I read it right. So it looks like 0201  
11                  is Stage 2 and above and this one is Stage 3 and  
12                  above. So can you help us understand why you  
13                  think getting rid of Stage 2 pressure ulcers,  
14                  which is still major issues, would be acceptable?

15                 MS. ANDERSON: I am going to turn to  
16                 my colleagues with nursing degrees.

17                 CO-CHAIR HANRAHAN: I don't know. I  
18                 mean it's probably the depth of the ulcer. You  
19                 know, the severity of the ulcer. And I really  
20                 don't know.

21                 MS. ANDERSON: I am not an expert on  
22                 pressure ulcers, I'm sorry to say. I think that

1 it is an NQF-endorsed measure and, therefore, the  
2 evidence has been enough that it was endorsed in  
3 this way. I am not versed on pressure ulcer  
4 stages.

5 Would anyone else like to comment?

6 CO-CHAIR HANRAHAN: I'd just like to  
7 say that what I like about this other measure is  
8 that it's focused on conditions that are most  
9 likely to have some kind of pressure associated -  
10 - pressure ulcer associated. So one of the  
11 problems with pressure ulcer measures is that  
12 it's not -- it's a rare event.

13 So, yeah, go ahead.

14 MEMBER MONSON: So I'm not a clinician  
15 but I've spent a lot of time in LTSS and long-  
16 term care, post-acute care. And what I've seen  
17 time and again on our own internal measures is  
18 that if you don't, and what the providers have in  
19 the past said, if you don't pay attention to  
20 pressure ulcers you have not only hospital  
21 complications but then also in these populations  
22 it leads to institutionalization.

1                   And so I would have to say I'd be very  
2                   troubled about ignoring Stage 2 pressure ulcers  
3                   because Stage 2 pressure ulcers from what I  
4                   understand -- again I'm not a clinician -- are  
5                   indicative of bigger problems too. Because that  
6                   means that you -- that means something is going  
7                   on in that facility that they're not paying  
8                   attention to whether chairfast or bed-bound  
9                   patients.

10                   And for this population, to ignore  
11                   that especially, again especially for this  
12                   population I think would be a big mistake.

13                   MEMBER WARSHAW: Yeah, I think  
14                   Michael's concern is legitimate. I think that a  
15                   Stage 2 ulcer means the skin is broken.  
16                   Something's happened that puts the person at some  
17                   risk and it could move to a Stage 3 or 4 pretty  
18                   quickly.

19                   I think the other issue with this  
20                   measure, I understand the convenience of having a  
21                   measure that has all these components to it but  
22                   we've made some progress on pressure ulcer



1 reduction in hospitals but if you bury it in this  
2 kind of measure, I'm not sure how the measure  
3 gets reported out, but is there, is it a  
4 cumulative success with this? Or if you fail in  
5 one portion of this do you fail the measure?

6 Like let's say you're great at  
7 everything except pressure ulcer reduction, would  
8 you still pass this measure?

9 MS. ANDERSON: My understanding is  
10 that indicators are available for monitoring  
11 patient safety and improvement and things like  
12 that but that there is a composite measure that  
13 does report indicators. I would have to do more  
14 looking to see how accessible that is.

15 MEMBER WARSHAW: I agree that, in  
16 summary, that we shouldn't accept Stage 2  
17 pressure ulcers in hospitals, and that if this  
18 doesn't allow for the providers to see where  
19 they're having errors and that somehow they're  
20 reflected in the reporting and this may not be  
21 sufficient to replace the one that we're going to  
22 get rid of.

1 CO-CHAIR HANRAHAN: Aline.

2 MEMBER HOLMES: Just to answer his  
3 question. You can report these indicators  
4 separately, pressure ulcers, PSI, separately for  
5 value-based purchasing, and it gets rolled up  
6 into this bigger measure. But a lot of Stage 2  
7 is probably reported on this measure, statewide  
8 reporting, so it's available just for that one  
9 measure.

10 MEMBER RASK: Yeah, I was going to  
11 follow up, make the same comment about the PSI90.  
12 When it's rolled up in the other, in the value-  
13 based purchasing and other programs, these  
14 different outcomes are weighted. So the  
15 different outcomes of pressure ulcers is actually  
16 weighted pretty highly. So it's not just a pure  
17 rate of it, it's a proportion of what is your  
18 rate of pressure ulcers, and then weighted and  
19 then it is risk adjusted. So it does get rolled  
20 up.

21 I think the issue of the pressure  
22 ulcer 2 versus 3 is important. I think in terms

1 of a claims-based measure, the issue is, it's  
2 claims data, it's not a physical exam. And so  
3 that's why it's more reliable as a level 3. It's  
4 not saying that the level 2, Stage 2 isn't  
5 important, it's just a validity and  
6 reproducibility issue.

7           You know, I think the benefits of this  
8 are that it focuses at the hospital and acute  
9 care facility level. The benefit of some of the  
10 other ones that are considered are that they are  
11 a little bit richer in terms of what they're  
12 going to offer clinically, but it's not in this  
13 hospital setting.

14           And, you know, as somebody who's done  
15 a lot of quality improvement work in hospitals, I  
16 think that there you find, if I were trying to  
17 speak for them and so to speak for them I'd say  
18 that on the one hand they'd say, okay, you picked  
19 this. Thank God it's something else you're not  
20 asking me to do. It matches something I'm being  
21 required to do for another program; I'm very  
22 happy.

1           But then I'm also going to say claims  
2       data is claims data. And what I see on a patient  
3       and what I see in their claims don't always match  
4       up.

5           MS. ANDERSON: And that was also  
6       described in the endorsement report from 2015  
7       that the committee was concerned about the use of  
8       claims-based measures, claims-based where there's  
9       measure reporting. However, they did endorse it  
10      as it is specified understanding that.

11          CO-CHAIR HANRAHAN: Gregg, did you  
12      want to say something? Okay.

13          Michael.

14          MEMBER MONSON: Fine. Because when I  
15      looked at I didn't see it as claims. I thought  
16      it said electronic. I didn't think it was  
17      claims, I thought it was EMR data that was,  
18      electronic clinical data is what it says here as  
19      the data source. So I just want to, I do want to  
20      clarify what -- oh, maybe I'm reading it wrong.  
21      I'm just reading what was on our worksheet. On  
22      our worksheet. That's my source of information,

1 so.

2 MEMBER HOLMES: It's claims data.  
3 That's where they pull it from. But it's based  
4 on the code -- the physician when he's completing  
5 the discharge form how properly identifies the  
6 pressure ulcer. Then they can pull that  
7 information code that this comes right from  
8 claims data. But it is based on what the  
9 physician documents at discharge.

10 CO-CHAIR HANRAHAN: Okay. Let's move  
11 to vote.

12 I thought we were going to vote on a  
13 previous slide and whether we will support the  
14 removal as an endorsed NQF measure.

15 MS. ANDERSON: Okay. So I would need  
16 a workgroup member or I'm getting from the group  
17 here I think that the vote is to remove 0201 as a  
18 measure that is no longer endorsed and replace it  
19 with 0531, Patient Safety for Selected  
20 Indicators.

21 We've got the vote at hand. There are  
22 five.

1 DR. MUKHERJEE: I think it might be  
2 helpful if we vote just to see, you know, the  
3 pressure ulcer, and then go through the five to  
4 see if any of the five, if one is moot, you know.

5 MS. ANDERSON: This is one of the  
6 five. Shall we move on to the others to look at  
7 them?

8 CO-CHAIR HANRAHAN: Sure.

9 MS. ANDERSON: Okay, let's do that.

10 So the next measure is 1789, Hospital-  
11 Wide All-Cause Unplanned Readmission Measure.

12 This measure is currently in the  
13 family of measures and does not include a  
14 specific element of pressure ulcers but is a  
15 hospital-wide unplanned risk standardized  
16 readmission rate within 30 days of hospital  
17 discharge.

18 Again it's a facility-level outcome  
19 measure and it is currently used in three  
20 separate programs: Medicare Shared Savings,  
21 Inpatient Hospital Quality Reporting, and  
22 Meaningful Use.

1                   Are there any questions or discussion  
2 about this measure? Seeing --

3                   MEMBER WARSHAW: It seems like a good  
4 measure. It's in our family but it doesn't  
5 really address the pressure ulcer issue. I mean  
6 because many of these will be fixed in the next  
7 setting, in the post-acute setting, so they'll  
8 never come back to the hospital. But it doesn't  
9 tell you what the hospital did.

10                  MS. ANDERSON: Okay. Moving on to the  
11 next slide.

12                  0679, Percent of High Risk Patients  
13 with Pressure Ulcers, Long Stay.

14                  So this percent of long stay residents  
15 are identified as high risk for pressure ulcers  
16 in nursing facility who have one or more Stage 2,  
17 Stage 4 or unstageable pressure ulcers reported  
18 in the target MDS assessment during their episode  
19 during the quarter.

20                  High risk populations are defined as  
21 those who are comatose or impaired in bed  
22 mobility or transfer, or are suffering from

1 malnutrition. Long stay residents are in at  
2 least 101 cumulative days of nursing facility  
3 care.

4 The measure is currently used in  
5 Nursing Home Quality Initiative and Nursing Home  
6 Compare programs. And the staff analysis is to  
7 consider it as an alternative because it does  
8 address the pressure ulcers directly but it is  
9 really limited to these high risk residents and  
10 does not address hospital-acquired pressure  
11 ulcers.

12 It also uses electronic clinical data  
13 that addresses burden and is used in federal  
14 programs which address the alignment.

15 CO-CHAIR HANRAHAN: One of the most  
16 obvious observations is that the pressure ulcer,  
17 the 0201, is hospital based and this is nursing  
18 home based. So I'm not sure you can replace one  
19 for the other.

20 MS. ANDERSON: Next slide.

21 MEMBER RASK: And I'd argue that  
22 they'd be two -- they're complementary measures.



1 MS. ANDERSON: So 0678, Percent of  
2 Residents or Patients With Pressure Ulcers that  
3 are New or Worsened, Short Stay.

4 So this is a percent of patients or  
5 short stay residents with Stage 2 risk to stage 4  
6 pressure ulcers that are new or worsened since  
7 admission. They are a risk adjusted outcome  
8 measure collected via clinical data. Specified  
9 for in-patient rehabilitation facilities, long-  
10 term care hospitals, nursing homes and  
11 facilities.

12 It's currently used in several  
13 programs for those settings, including the IRF  
14 Quality Reporting, LTC Quality Reporting, and  
15 Nursing Home Quality Initiative and Home Compare.

16 Staff analysis, it's considered as an  
17 alternative. Specified for multiple long-term  
18 care settings but does not address hospital-  
19 acquired pressure ulcers.

20 It's a risk adjusted focus on high  
21 risk residents -- sorry, it does not focus on  
22 high risk residents. It's risk adjusted, uses

1 electronic clinical data, and it's in use in  
2 multiple programs.

3 Questions or discussion about this  
4 measure?

5 MEMBER MONSON: I would just say that  
6 this is the analog to the hospital one; right?  
7 Short stay. You know, 25 days in the nursing  
8 facility on average. So this would be the analog  
9 to the hospital one at 0201, except that it's  
10 clinical, it's MDS based but I don't think  
11 there's anything comparable for the hospitals.

12 MS. ANDERSON: Okay. The next slide  
13 is 0538, Pressure Ulcer Prevention Care.

14 It's a percentage of three components.  
15 Since we developed the materials this measure has  
16 been put into reserve status because it is high  
17 performance. So while it is presented in front  
18 of you as something to consider, I would note  
19 that it is reserve status endorsement.

20 Perhaps nursing can help me. Reserve  
21 side is something not -- the committee that  
22 recently reviewed this measure noted that it has

1 high performance across populations. And the  
2 recent data is 90 to 95 percent compliance and  
3 success reporting with this measure in reporting.

4 Therefore, we focus on using available  
5 resources on areas that do have opportunities for  
6 quality improvement. And because they is such  
7 high success with this measure we're looking to  
8 continue to identify other areas where quality  
9 improvement needs to be made and energy focused  
10 that way. Home health.

11 CO-CHAIR HANRAHAN: Discussion?

12 MEMBER RASK: My concern with it is  
13 besides home health and also it's a process  
14 measure where some of the others are really  
15 outcome measures. And if we have the opportunity  
16 for outcome measures, that what actually is the  
17 incidence of pressure ulcers versus are you  
18 documenting appropriately, I'd prefer an outcome  
19 versus documentation.

20 CO-CHAIR HANRAHAN: Clarke.

21 MEMBER ROSS: But I think this is the  
22 only measure for the home health quality

1 reporting related to pressure ulcers. So the  
2 fact is are we willing to stay let's excuse home  
3 health settings because of the weakness of the  
4 measure? Some of us are not willing to do that.

5 So we heard in the post-acute care  
6 long-term care only 6 percent of home health  
7 clients have pressure ulcers. So we're willing  
8 to risk 6 percent of the population having  
9 serious illness or dying.

10 So that's the problem with all these  
11 measures, they are limited to one little setting  
12 under a couple little conditions. But I'm not  
13 willing to exempt settings from such a serious  
14 health condition, even though it only affects,  
15 prevalence-wise, a small percentage of the  
16 population served.

17 CO-CHAIR HANRAHAN: Kim.

18 MEMBER RASK: To be clear, I wasn't  
19 saying we shouldn't measure it in home health.  
20 I'm saying I don't think this measure, to adopt  
21 this as a replacement for an outcome measure in  
22 hospital setting would be appropriate.

1 CO-CHAIR HANRAHAN: So the observation  
2 I have is that 0201 is hospital based. It is  
3 Stage 2 which is an earlier stage of identifying  
4 an ulcer.

5 The rest of them are site different.

6 So the question we have right now on  
7 the table is do we endorse NQF to remove the  
8 0201? Am I right about that?

9 MEMBER RASK: The PSI90 is hospital  
10 specific.

11 CO-CHAIR HANRAHAN: Yes. But it also  
12 was Stage 3 and above.

13 MEMBER RASK: Stage 3, yes.

14 CO-CHAIR HANRAHAN: And it also was  
15 specified according to a particular diagnosis or  
16 condition versus 0201. Yeah, there was a whole -  
17 -

18 MEMBER RASK: Those were other  
19 measures that are included as part of the PSI90  
20 along with the pressure ulcer measure. So it  
21 moves the pressure ulcer measure into being one  
22 of the composites, small free-standing pressure

1       ulcers.

2                   CO-CHAIR HANRAHAN:   Okay.   I  
3       misinterpreted that.

4                   MS. ANDERSON:   So the question on the  
5       table is if we can remove 0201 from the family  
6       and if there is an alternative that the workgroup  
7       would like to use to replace this measure that's  
8       no longer being maintained.

9                   I suggest that we take one decision at  
10      a time and vote first on the removal, now that  
11      you have seen the alternative.   And then we would  
12      need a workgroup member to nominate one of the  
13      measures for addition to the family.

14                  CO-CHAIR HANRAHAN:   Aline.

15                  MEMBER HOLMES:   I just wanted to make  
16      a note, there is another alternative.   NDNQI,  
17      which is the Nursing Database Quality Indicators,  
18      that's managed by the American Nursing Center,  
19      Credentialing Center, does have two pressure  
20      ulcer indicators that are used in house; both a  
21      prevalence and an incident measure.

22                  The problem with it is that they are

1 not widely used across all. Any hospital that's  
2 going on a journey may use these measures. So it  
3 is more of a problem. It's not as widely done  
4 but it is more clinically based also.

5 Oh no, they're not National Quality  
6 Forum endorsed but they're -- I'm just saying  
7 there's other sources of this data.

8 CO-CHAIR HANRAHAN: Actually, NDNQI  
9 was absorbed by Press Ganey.

10 MEMBER HOLMES: I understand that.

11 CO-CHAIR HANRAHAN: Yeah.

12 MEMBER HOLMES: But I get that data as  
13 part of the HEN survey uses the exact same  
14 measures across.

15 CO-CHAIR HANRAHAN: They are using  
16 those measures?

17 MEMBER HOLMES: They are using exactly  
18 the same. Because I was getting it for our work  
19 before they went to Press Ganey and afterwards.  
20 So it's in this transition.

21 MEMBER AGUIAR: So I just have a  
22 question for the group because this is not a --

1 pressure ulcer is not an area that I am familiar  
2 with. And I'm not a clinical person.

3 But is it, is it more of a concern in  
4 a hospital based setting or the long-term care  
5 setting? Because it sounds like you have to  
6 choose between you're facing one that's hospital  
7 setting with another hospital setting or with one  
8 that's specific to nursing homes. And so if  
9 anyone has information on that, that would help  
10 me to make a decision.

11 CO-CHAIR HANRAHAN: Clarke, do you  
12 want to address that?

13 MEMBER ROSS: I just want to address  
14 it from the factor of a person who's paralyzed  
15 and uses a chair for everyday life. It doesn't  
16 make a difference where they are. They're at  
17 home.

18 Christopher Reeve was in his home with  
19 24-hour care, the best in the world. And because  
20 he was paralyzed, no one caught the little  
21 pressure ulcer in his rear and it got infected  
22 and he died.



1                   So some of it is patient  
2     characteristic. And this is -- so I work with a  
3     lot of professional people who use chairs and who  
4     are paralyzed. Every one of them have had  
5     pressure ulcer situations and every one of them  
6     is lucky it was detected early enough. Little,  
7     you know, dime-size red dot. And so maybe for  
8     other conditions the setting is important. A  
9     person who is paralyzed and uses a chair, doesn't  
10    make a difference where the setting is.

11                  CO-CHAIR HANRAHAN: I think hospitals  
12    because the stay is so short, the length of stay  
13    is so short, it's very unlikely you're going to  
14    develop one that you can attribute to that  
15    hospital stay. But I think what Clarke is saying  
16    is no matter where it is, it's a really  
17    significant neglect in care and process.

18                  Go ahead, George.

19                  MEMBER ANDREWS: Yeah. In answer to  
20    Christine's question I would say that you have  
21    even in an acute setting situations where you are  
22    there lying facing upwards for a long time,

1 especially if you're in an intensive care unit  
2 and you have multiple lines. And because of the  
3 lines or for no reason you may not be moved or  
4 turned, even though they try to. So you are at  
5 the higher risk for developing, if you are there  
6 three weeks, four weeks, which is not uncommon,  
7 to develop the stages of an ulcer.

8 So it would apply even though it's not  
9 to the level that you would see in a long-term  
10 care facility.

11 MS. ANDERSON: And I would just add  
12 that while I said to replace with one measure, I  
13 mean to vote on one measure at a time. The  
14 workgroup may choose to have more than one  
15 pressure ulcer measure in the family. And it  
16 could be for different settings, but we need to  
17 vote on them each one at a time.

18 And I would also emphasize the measure  
19 selection criteria specifically emphasizes  
20 parsimony. We already have 76 measures in the  
21 family. We did move a few. But adding two to  
22 replace one is something to take in mind. And

1       that's my reminder of parsimony for the workgroup  
2       members. And I ensured that I remember that.

3               That's the process. Administrative  
4       note.

5               CO-CHAIR HANRAHAN: Kimberly, you want  
6       to say something?

7               MEMBER RASK: Alice pointed out very  
8       wisely to hold up the exclusion criteria for the  
9       PSI90. And the notion that what we're -- since  
10      our specific focus is dual eligible in that  
11      patient population, what I would ask, and many of  
12      the group here who have more experience than I do  
13      on what would be more relevant for this patient  
14      population, but for the PSI90 in the hospital  
15      setting you exclude high risk people, which means  
16      you exclude anyone with an ICD-9 close for  
17      hemiplegia, paraplegia, quadriplegia, spina  
18      bifida, brain damage, debridement, pedicle graft,  
19      major operating procedure, transfer or transfer  
20      to skilled nurse facility.

21              And so after reading that I'm kind of  
22      wondering rather than the PSI90 for dual

1       eligibles, might we be better off with one of the  
2       other measures that's using MDS in a long-term  
3       care facility rather than the PSI90?

4               CO-CHAIR HANRAHAN: This is the 0531.

5               MS. ANDERSON: We will first take a  
6       vote -- out of clarity I'll say we'll first take  
7       a vote to remove 0201 from the family. It sounds  
8       like we, the group is, has available alternatives  
9       that they appreciate as an alternative to that  
10      measure. So I think we -- at time that we can  
11      take that vote. And then we will vote on the  
12      inclusion of alternatives to 0201.

13              Is that, is that accurate? Okay. We  
14      will go to the vote.

15              Okay, Janine, vote to remove 0201.

16              MS. AMIRAULT: Okay. So for 0201, for  
17      removal from family of measures, one being yes  
18      removed, two being no.

19              (Vote.)

20              MS. AMIRAULT: Okay, so we have 11 for  
21      yes, remove; and 6 for no. And based on the 65  
22      percentage, the consensus is to remove.

1 MS. ANDERSON: Thank you.

2 CO-CHAIR HANSEN: We're teaming up  
3 here in the process of going back then to looking  
4 at the other alternatives that we discussed and  
5 to see if one of those measures rises more to the  
6 top that we would like to choose to vote on. So,  
7 and is there somebody who would like to propose,  
8 given the discussion that we had on slide 84, the  
9 six -- excuse me, five items that we have?

10 MEMBER RASK: I would like to propose  
11 that we consider adding the 0678, the residents  
12 or patients with a short stay, which seems closer  
13 and similar. It's based on MDS data which will  
14 be a little bit richer and it would be more  
15 appropriate for, probably more relevant for our  
16 dual eligibles than what it's replacing.

17 CO-CHAIR HANRAHAN: Any other  
18 comments?

19 MEMBER MONSON: So if -- I'm  
20 disappointed about the other one, but let it go -  
21 - so if we're going to move away from the  
22 hospital, then a short stay in a nursing facility

1 is probably the wrong place for us to focus,  
2 especially with the way the policy environment is  
3 moving and the payment environment. We're going  
4 to see a lot fewer patients going through nursing  
5 facilities for rehab.

6 Not that there won't be a lot -- there  
7 won't be some but it will be much lower than it  
8 is today, which would then indicate that if you  
9 want to capture it you would want to do the long  
10 stay measure in nursing homes and then maybe some  
11 modified home health measure to capture the short  
12 stay folks.

13 MS. ANDERSON: So I'm going to briefly  
14 review 0678 and 0679 for the workgroup benefit.

15 0678 is described in slide 88. It is  
16 Percent of New -- of patients of -- Percent of  
17 Patients or Short Stay Residents with Stage 2 to  
18 Stage 4 Pressure Ulcers That Are New Or Worsened  
19 Since Admission. It's a risk-adjusted outcome  
20 measure collected via electronic data, specified  
21 for IRFs, LTCs and nursing homes, and currently  
22 used in three programs for those settings.

1           The alternative that's been proposed  
2   is 0679 or also has been proposed for addition to  
3   the family is 0679, Percent of High Risk  
4   Residents with Pressure Ulcers, percent of high  
5   risk residents which are individuals who are  
6   comatose or impaired in bed mobility or  
7   transferabilities, or suffering from  
8   malnutrition. And those high risk residents who  
9   have one or more Stage 2 to Stage 4 or  
10   unstageable pressure ulcers reported in the MDS  
11   data. It's specified for nursing home facilities  
12   and currently in Nursing Home Quality Initiative  
13   programs.

14           CO-CHAIR HANRAHAN: Discussion?

15           Gregg.

16           MEMBER WARSHAW: I think that both  
17   these measures, I believe that it's important to  
18   identify quality of care around pressure ulcers  
19   in all settings and in all circumstances. So I  
20   think a short stay one, although I agree to where  
21   the trends are going, it does also reflect  
22   pressure ulcers that are identified in that

1       setting that get worse.

2               As most of you know that work in this  
3       area, because of the quality measures, nursing  
4       homes are much more aggressive to examine skin at  
5       the time of admission from hospital. I mean it  
6       is possible to identify even damage that hasn't  
7       appeared yet. They take pictures and they are  
8       making sure that it's clear that this is  
9       something that happened in the hospital, not in  
10      the nursing home. And then we deal with it from  
11      that point on.

12             So being -- keeping people alert to  
13      examining the patient when they come in and being  
14      alert to making sure that things don't get worse  
15      during the stay in the nursing home or in the  
16      post-acute setting is a good, is a good measure.  
17      And so I think the short-term one is a good one.

18             And this long-term measure is another  
19      quality measure based on people who are bed bound  
20      for long periods of time. And they're not  
21      duplicative. They're both important.

22             So I realize we don't want to have too



1 many measures but they're both important.

2 CO-CHAIR HANRAHAN: Shall we vote?

3 MS. ANDERSON: Okay, first we'll vote  
4 on the inclusion of 0678, Percent of Residents or  
5 Patients With Pressure Ulcers That Are New Or  
6 Worsened.

7 We will take a second vote that is  
8 independent on 0679. So it may be that the  
9 workgroup votes to include both of them or that  
10 it votes only to include one. But we're not  
11 comparing them in the voting; we compared them in  
12 our discussion. Is that sufficient?

13 MEMBER WARSHAW: Yes.

14 MS. ANDERSON: Okay. So 0678 is the  
15 vote. And the vote is to include it in the  
16 family.

17 Janine.

18 MS. AMIRAULT: Okay. So for 0678 for  
19 addition to the family of measures, one being  
20 yes, two being no.

21 (Vote.)

22 MS. AMIRAULT: Okay, so for 0678 to

1 the addition to the family of measures, 15 for  
2 yes, 2 for no. Based on the 88 percent  
3 consensus, to be added.

4 MS. ANDERSON: Now we will vote on  
5 0679 which is Percent of High Risk Residents With  
6 Pressure Ulcers, Long Stay.

7 MS. AMIRAULT: Okay. So for 0679 on  
8 the addition to the family of measures, one being  
9 yes, two being no.

10 (Vote.)

11 MS. AMIRAULT: Okay. So for 0679 we  
12 have 16 for yes to be added to the family, and 1  
13 for no. Based on the percentage, consensus is to  
14 add this to the family.

15 CO-CHAIR HANRAHAN: Michael.

16 MEMBER MONSON: So I think these are  
17 great measures. Very happy that they're in.

18 But I do think that there's maybe  
19 another measure gap that we have here which is  
20 all these measures, with the exception of the  
21 long stay measure which is only going to capture  
22 a small percentage of the population, are really

1 acute or post-acute measures. And so we've got  
2 the vast majority of people who are dual  
3 eligibles who are out in the community receiving  
4 HCBS services and we have no measure around  
5 pressure ulcers or wounds for them.

6 And I think to build on what Clarke  
7 was saying, I mean that's when Christopher Reeve  
8 had his issue. And that's when people end up  
9 with wounds and went back to a hospital or into a  
10 hospital or end up institutionalized. So I don't  
11 think we have a validated measure right now for  
12 HCBS individuals on Medicaid on long-term  
13 services reports. And I think that that's a big  
14 gap.

15 MS. ANDERSON: We think that's a great  
16 question and point of discussion for tomorrow's  
17 presentation on the ongoing HCBS project as well.

18 So we are on slide 91, and we're going  
19 to consider measures that have been newly  
20 endorsed in the family. There are six newly  
21 endorsed measures of health and well-being. And  
22 the staff preliminary analysis for these measures

1 was not to recommend since they are condition-  
2 specific and do not address priority area.

3 For cardiovascular medication  
4 measurement, ACE inhibitor, ACE/ARB measure.

5 Three measures for end-stage renal  
6 disease which so those measures were condition-  
7 specific.

8 There was also staff of measures that  
9 are not appropriate for the population because  
10 they are pediatric measures. So there are two  
11 measures of pediatric care.

12 Does anyone have any discussion or  
13 questions about these measures?

14 (No response.)

15 MS. ANDERSON: Hearing none, we will  
16 move on the next slide of four newly-endorsed  
17 measures that the staff preliminary analysis is  
18 not to recommend them because they are condition-  
19 specific and do not address priority areas for  
20 the population.

21 Those measures are carotid artery  
22 stenting; statin use in persons with diabetes;

1 average change in functional status following  
2 lumbar spine fusion surgery; and average change  
3 in functional status following total knee  
4 replacement.

5 And we'll, just as a reminder, we'll  
6 be considering functional status measures later  
7 this afternoon.

8 CO-CHAIR HANRAHAN: Megan, a question.  
9 Are you saying they're not endorsed because, did  
10 you say because they're condition-specific? Does  
11 that mean that these are measures that are  
12 elsewhere and we're not endorsing them  
13 specifically for the dual eligibles?

14 MS. ANDERSON: These are newly-  
15 endorsed measures. These are newly-endorsed  
16 measures that have been endorsed by NQF Steering  
17 Committee that the measure applications  
18 partnership can consider for inclusion to the  
19 family for dual beneficiaries. And as staff  
20 building on previous recommendations from this  
21 workgroup, we've looked at them and determined  
22 that they do not address the priority gap area,

1 or that they are condition-specific.

2 And but we also -- and that there are  
3 other measures in the case of the diabetes or  
4 other measures, more comprehensive diabetes  
5 measures in the family that we did not perceive  
6 that see they would be preferred over the  
7 measures in the family.

8 CO-CHAIR HANRAHAN: So George and then  
9 Kimberly and then Joan.

10 MEMBER ANDREWS: Yeah, just to  
11 clarify. Is the recommendation from the staff  
12 that, for example, the cardiovascular angiotensin  
13 inhibitors or ARBs, this particular measure be  
14 removed because it does not --

15 MS. ANDERSON: It's not being removed  
16 from anything. It's not in the family. It's a  
17 brand new endorsed measure that is highly  
18 condition-specific. And we wanted you to be  
19 informed of the newly-endorsed measures. And as  
20 staff we don't have the authority to say that  
21 they don't belong in the family. And this is  
22 maintenance of the family.

1           So if you would like to bring them for  
2       discussion for inclusion in the family, you have  
3       the opportunity to do that.

4           MEMBER ANDREWS: Yes. As I'm looking  
5       at the measures of health and well-being, we do  
6       know health and well-being relies a lot on  
7       prevention. And ACE inhibition therapy in  
8       diabetics for prevention of renal disease are  
9       being used in diabetics the same. ACE used in  
10      hypertensives, particularly if they have  
11      diabetes, very strongly recommended. ACE or ARB  
12      used in heart failure.

13           So if we're talking about somebody's  
14      well-being being well-contained and improved,  
15      you're not going to be able to achieve without  
16      these medications. So for me these are must-have  
17      medications in cardiovascular disease management  
18      and for wellness and well-being.

19           MS. ANDERSON: Primarily these  
20      measures were endorsed, the first two were  
21      endorsed under the cardiovascular project. But  
22      measures of health and well-being were on the

1 other side. Just how they were broken up.

2 If you would like to bring them  
3 forward for consideration for inclusion in the  
4 family, which it sounds like you do, we can  
5 discuss that.

6 MEMBER ANDREWS: Yes. The answer is  
7 yes.

8 MS. ANDERSON: Okay. All of them or  
9 -- all of the four measures on this slide or the  
10 top two, George?

11 MEMBER ANDREWS: My statement was  
12 specific to the first two.

13 MS. ANDERSON: Okay.

14 MEMBER ANDREWS: I'm sorry, yes,  
15 health and well-being. Yes, 1662.

16 MS. ANDERSON: Okay. Okay, I don't  
17 have a slide prepared on that but we will discuss  
18 it.

19 There are other cards up, however, so  
20 would we like to move on to discuss that measure  
21 or would you like to share your thoughts?  
22 Others?



1 CO-CHAIR HANRAHAN: Kimberly.

2 MEMBER RASK: One other has raised the  
3 issue on the statin and the diabetes one. And I  
4 don't know if -- I mean I'm wondering if some of  
5 these require enough information and looking  
6 around the path is that something -- being a  
7 first time here at this group I don't know to  
8 what extent these things can fit into the purview  
9 of what we're covering right now.

10 But thinking both about the  
11 cardiovascular and the diabetes, I know that  
12 there are other composite measures for diabetes  
13 care. And so to some extent it may already be  
14 included in there but with the statin being a new  
15 one I'm also thinking in dual eligibles with co-  
16 existing behavioral health and medical conditions  
17 and the high rate of diabetes and cardiovascular  
18 disease, is that something that's of particular  
19 importance for dual eligibles that we might want  
20 to consider measures that do get into  
21 cardiovascular disease and diabetes.

22 And I don't know, that's my lack of

1 knowledge, to what extent the clinical measures  
2 that are already part of the family might  
3 incorporate that or whether there should be an  
4 opportunity for us to bring in some measures that  
5 would be relevant.

6 DR. MUKHERJEE: So we do have 0018  
7 which is Controlling Blood Pressure, and it's  
8 controlling blood pressure with the purpose of  
9 ESRD and controlling or preventing ESRD, end-  
10 stage renal disease.

11 So we do have one. It's an outcome  
12 measure. It's endorsed. And it's control of  
13 hypertension with medication. It doesn't specify  
14 ACE, ARB or statins, but it goes with the blood  
15 pressure ranges. So there is one, and it's 0018.

16 CO-CHAIR HANSEN: And I believe  
17 tomorrow morning we'll be actually considering  
18 some of the well-being measures. So this will  
19 continue.

20 MS. ANDERSON: So I think your  
21 observations are right on. Where I don't have  
22 this information at my fingertips -- I have them

1 at my fingertips but I don't have it ready to  
2 present. So what we did in the staff preliminary  
3 analysis was to look at all of the available  
4 newly-endorsed measures. And as staff, it's  
5 important that we -- that we show these to you,  
6 and this is a perfect example of why.

7 We have other measures that do address  
8 cardiovascular care and diabetes care that are  
9 more comprehensive or are already included in the  
10 family. And so the staff preliminary analysis  
11 takes that into consideration, took into  
12 consideration burden, parsimony and the  
13 priorities of the workgroup. It did not  
14 recommend the measures for consideration for  
15 inclusion in the family.

16 Because of your interest in them, what  
17 we can do is this evening I can prepare slides on  
18 these two measures for consideration tomorrow  
19 morning for inclusion in the family. And then I  
20 will be able to have information about the use of  
21 them in other federal programs. However, because  
22 they are brand new measures, newly endorsed, it's

1 unlikely that they are used in federal programs  
2 or are otherwise aligned.

3 And so I'm happy to do -- we're happy  
4 to do that overnight and, if that is  
5 satisfactory, for the workgroup to consider them  
6 tomorrow morning.

7 So I have 1662 as one measure that  
8 we're going to consider tomorrow morning. And is  
9 there another measure? 2712, Statin Use in  
10 Persons With Diabetes.

11 Are there any other measures the  
12 workgroup would like to consider for addition to  
13 the family tomorrow morning?

14 (No response.)

15 MS. ANDERSON: Okay. We are close to  
16 on time, which is great. Thank you all. We need  
17 to go to public comment at 3:00. And that is  
18 what time it is.

19 CO-CHAIR HANSEN: Operator, would you  
20 please let us know if there are any members of  
21 the public who would like to ask questions and  
22 make comment, and those also who are in the room.

1 OPERATOR: Yes, ma'am. At this time,  
2 if you would like to comment, please press star  
3 then the number one.

4 (Pause.)

5 OPERATOR: There are no public  
6 comments from the phone line.

7 CO-CHAIR HANSEN: Thank you, Operator.  
8 There are some other measures on safety. And if  
9 you would go to slide number 93.

10 MS. ANDERSON: So while the staff  
11 preliminary analysis had ruled out the measures,  
12 and we'll bring two of them back for you tomorrow  
13 morning, we did -- Jim, do you have something  
14 you'd like to add? No.

15 Okay. We did bring additional  
16 measures for your consideration on patient  
17 safety. There are three measures on slide 93 for  
18 your consideration, two of which the staff  
19 recommends that you consider for inclusion in the  
20 family, and a third which was condition-specific.  
21 But because they are the three patient safety  
22 medication measures, we will present them

1 together.

2 The first is 2720: National Healthcare  
3 Safety Network Antimicrobial Use. The  
4 preliminary analysis considered it for addition  
5 to the family because it addresses an important  
6 area for patient safety, structure and culture.  
7 It does not address high-leverage opportunity for  
8 measurement or priority gap area directly.

9 And 2723: Wrong-Patient Retract-and-  
10 Reorder measure, which is a staff pick because  
11 the preliminary analysis is to consider it for  
12 addition to the family because it is an outcome  
13 measure and addresses patient safety, structure  
14 and culture, but does not address the high-  
15 leverage opportunities and the gap areas as  
16 specifically as some of the other measures we  
17 considered earlier this morning -- excuse me,  
18 this afternoon.

19 CO-CHAIR HANSEN: Megan, I know there  
20 is a definition here. But since we're meeting in  
21 person would you put some more texture to that  
22 patient retract-and-reorder?

1 MS. ANDERSON: In two slides.

2 CO-CHAIR HANSEN: Right, sorry.

3 MS. ANDERSON: So the next slide is  
4 2720: National Healthcare Safety Network.

5 It's a measure that assesses  
6 antimicrobial use in hospitals based on  
7 medication administration data that hospitals  
8 collect electronically at the point of care and  
9 report via electronic file submissions to CDC.

10 And it's a risk-adjusted process  
11 measure. It's specific for hospitals and acute  
12 care facilities, in-patient rehabilitation  
13 facilities, long-term acute care hospitals.

14 And it is a patient safety measure  
15 that addresses structure and culture but does not  
16 address one of the specific six gap areas that  
17 this workgroup has previously listed.

18 Does any workgroup member have  
19 questions about this measure?

20 (No response.)

21 MS. ANDERSON: Okay. Gregg, is your  
22 card up? Gregg, is your card up?

1 MEMBER WARSHAW: No.

2 MS. ANDERSON: No. Okay.

3 The next measure is 2723: Wrong-  
4 Patient Retract-and-Reorder measure. It's an  
5 event -- it's when an event occurs as an order is  
6 replaced -- is placed on a patient in an EHR, is  
7 retracted within ten minutes, and then the same  
8 clinician places the same order on a different  
9 patient within the next ten minutes.

10 It's a rate calculated by dividing the  
11 wrong-patient reorder -- retract-and-reorder  
12 event by the total orders examined. It's a risk-  
13 adjusted outcome measure. It's specified for  
14 clinician, integrated delivery systems, and it's  
15 collected from electronic medical records.

16 And we wanted to recognize that there  
17 is a related medication measure in the family  
18 currently. It's 2456: Medication Reconciliation,  
19 which is the number of unintentional medication  
20 discrepancies per patient. So we have a  
21 medication measure that is medication  
22 discrepancies per patient in the family



1 currently, and we'd like the workgroup to  
2 consider and discuss the inclusion or the  
3 replacement of that measure with these  
4 alternatives.

5 Is there any workgroup discussion on  
6 2723?

7 CO-CHAIR HANSEN: Given the fact that  
8 there is another measure, the staff now recommend  
9 this one, could you share what some of the  
10 benefits of this might be over an existing one?

11 MS. ANDERSON: I don't know that I  
12 would. I didn't compare and contrast the two  
13 measures, but of the newly available measures, if  
14 the workgroup wanted to consider them, this would  
15 be one of them. I am happy to look up 2456.

16 (Pause.)

17 MS. ANDERSON: And 2456 is an outcome  
18 -- NQF-endorsed outcome measure. It is  
19 Medication Reconciliation, Number of  
20 Unintentional Medication Discrepancies Per  
21 Patient. It is a measure that assesses the  
22 actual quality of medication reconciliation

1 process by identifying errors in admission and  
2 discharge medication orders due to problems with  
3 medication reconciliation process. The target  
4 population is any hospitalized adult patient and  
5 the time frame is within the period of  
6 hospitalization.

7 It is not risk-adjusted. It excludes  
8 patients that are discharged or expire before the  
9 gold standard medication list can be obtained.  
10 It addresses National Quality Strategy priority  
11 of effective communication care coordination.

12 It is specified for a hospital level  
13 of analysis -- excuse me, hospital care setting  
14 and facility level of analysis. It is also  
15 collected via electronic clinical data. And it  
16 is included in the CMMI priority measures for  
17 monitoring and evaluation, hospital in-patient  
18 quality reporting, hospital value-based  
19 purchasing, and physician-based quality --  
20 physician-based value -- physician's value-based  
21 payment modifier.

22 So the measure that's currently in the

1 family is an outcome measure for hospitals that  
2 is currently in federal programs and is  
3 electronically collected.

4 MEMBER HOLMES: I just have a question  
5 about it. Do we know how many of the electronic  
6 health records systems actually have this  
7 capability that are out there? I don't know how  
8 -- unless it was programmed into it.

9 MS. ANDERSON: I don't remember the  
10 number but the retract-and-reorder measure I  
11 think, I recently read the report, and that was a  
12 concern from the Endorsement Committee. However,  
13 they noted that the trend and the strong  
14 encouragement is for development and  
15 implementation of federal programs -- or of  
16 electronic records for the future. So it's a  
17 forward-looking measure.

18 And the measure that is previous to  
19 this one, 2720, is also limited but it's an NHSN  
20 so it's a CDC measure. Again, not everyone's  
21 using it. But the people who are -- the programs  
22 -- facilities that are participating are using

1 it, but it's not in any federal programs per se.  
2 It's in the CDC collection, data collection.

3 MEMBER HOLMES: I just -- based on  
4 what I know is a lot of the hospitals in our area  
5 that's not something that they're tracking right  
6 now. So that's why I asked the -- they're  
7 tracking medication reconciliation because it is  
8 a requirement for CMS and Joint Commission, but  
9 I'm not sure that that's something that's even  
10 built in. I'd have to even find out how to do  
11 it.

12 And then there's a question about --  
13 we don't have any, but there are a lot of  
14 critical access hospitals that have very minimal  
15 electronic health records systems.

16 MEMBER STUART: So I think the  
17 majority of medication errors occur in the  
18 admission and discharge processes where the  
19 transfer of that information is not well done.  
20 And, you know, I'd be curious to know how many  
21 within this short time frame, ten minutes, given  
22 the limitations of all of this, if it's future-

1 looking then maybe we should hold it to the  
2 future when we have a little bit more evidence  
3 around it and stay with the measure we have.

4 CO-CHAIR HANSEN: Kimberly.

5 MEMBER RASK: I really see them as two  
6 different measures -- or that they're measuring  
7 two different things; sorry. So I think, you  
8 know, MedRec I think also has a lot to do with  
9 care coordination, along with not making  
10 mistakes, but how are people communicating?

11 And this is more of an almost -- what  
12 do you call it? A counterbalancing measure where  
13 you're kind of saying, okay, we are moving to  
14 electronic health records but there are now some  
15 concerns about mistakes that happen with folks  
16 using electronic health records and the screens  
17 and what's available and what's not.

18 And this is kind of measuring that  
19 sort of problem, which is something different  
20 from care coordination or from MedRec. I mean,  
21 this order could be a test. It could be a x-ray  
22 on the wrong person. I'm assuming as I read it,

1       it could be -- it could be any number of things.

2               So I think that it may be forward  
3       thinking in terms of the number of places that  
4       could calculate it right now. What I do like  
5       about it is it becomes a way to be able to make  
6       sure that as people are moving and putting new  
7       processes, just because you make it electronic  
8       doesn't make it necessarily better. You might  
9       build in more mistakes and this becomes a way to  
10      kind of monitor what the rate of that is and are  
11      there in fact -- you know, this is like being  
12      able to -- one of the few times in healthcare  
13      where we can get the near miss. We usually get  
14      the full miss.

15              And this would be a way to  
16      electronically get a near miss without it being  
17      as resource intensive as having to do chart  
18      review or hope that someone would anonymously  
19      report it.

20              CO-CHAIR HANRAHAN: Gregg, did you  
21      have your --

22              MEMBER WARSHAW: Yeah, I agree with

1 all Kimberly's comments. And I think this  
2 particular -- the medication reconciliation is  
3 critical across the continuum. And I couldn't  
4 quite follow the measure discussion but I'm sure  
5 we'll have more measures that talk about  
6 medication reconciliation.

7 This is different. This is an EHR  
8 kind of opportunity to try to, as you're  
9 describing -- this would really be like if this  
10 was too high then you'd want to start looking for  
11 the ones that weren't corrected in ten minutes.

12 I mean the fact that it's retracted in  
13 ten minutes means no harm was done. So that's  
14 actually a good thing. You just didn't want to  
15 have too many of these going on because then it  
16 means some of them probably weren't caught.

17 So this measure is interesting but I'm  
18 not quite sure I can fully wrap my head around it  
19 yet. It is pretty serious.

20 CO-CHAIR HANRAHAN: I say ditto. It's  
21 I'm having a hard time wrapping my head around  
22 the significance of this. I mean, what if I

1 write in the record, you know, make a note and I  
2 just -- it's something, there's nothing, like  
3 it's a few words. And I go to the next record  
4 and then it's counted as a -- you know, a  
5 retract-and-reorder and somehow there's some  
6 punitive response to that. I mean it's just too  
7 loosey-goosey about what it is about.

8 MEMBER WARSHAW: Well, it is true that  
9 in the electronic health record when you sign an  
10 order it goes into the system. And some systems  
11 it's easier or harder to retract. But I guess --  
12 I work mostly in the out-patient setting, but  
13 when I make a mistake in the out-patient setting,  
14 I have to work really quickly to retract it. And  
15 it is easy to make mistakes, but the important  
16 thing is that they're identified quickly and  
17 corrected.

18 MS. ANDERSON: The Steering Committee  
19 worked with the developer and steward to  
20 understand that this measure should be used for  
21 quality improvement and not for payment until  
22 further understanding -- there's further



1 understanding about the data. And that  
2 specifically the measure should not be used to  
3 punish clinicians and providers. I'll just  
4 interject that commentary from the Steering  
5 Committee.

6 MEMBER BUHR: And I would agree with  
7 what's been said in that to me it doesn't seem  
8 like it's an outcome measure but it's not  
9 measuring an outcome that I really care that much  
10 about. I mean it's not -- it's a good thing if  
11 you're catching it, like Gregg said. So I don't  
12 know. I don't know.

13 Like, you know, as an example in an  
14 out-patient setting, my father-in-law recently  
15 went to the Urgent Care and went to the pharmacy  
16 and came home and he had two antibiotics. And  
17 the discharge instruction said to take one of  
18 them but he had two different ones in his  
19 pharmacy bag and so that didn't get caught. They  
20 obviously changed their mind or something but  
21 they didn't retract the first one.

22 So that's a worse outcome. It would

1 be better if they had retracted it. So, I don't  
2 know, it doesn't seem like we should put that  
3 much energy into this measure.

4 CO-CHAIR HANRAHAN: Thank you. I  
5 think we're at a stage where, you know, this is a  
6 different category. It's a near miss. It's a  
7 quality improvement component. What I've heard  
8 is that somebody -- some people feel it might be  
9 a little premature. On the other hand, some, you  
10 know, feel that it might be a good QA procedure.

11 What we need from a process standpoint  
12 right now that, you know, it's not something we  
13 have to actually include, but we need a  
14 recommendation if we are from a workgroup member  
15 on the table so that the larger group can vote  
16 upon it. So is there a nomination of this  
17 particular measure at this time?

18 Oh, I'm sorry, Tom. I forgot. I  
19 didn't see you.

20 MEMBER LUTZOW: Yeah, I'm surprised at  
21 the level of staff enthusiasm around this  
22 measure. My question would be, not that it's a

1 bad measure, but does it rise to the occasion?

2 Does it have the requisite weight to get our

3 attention?

4 And aren't there other things of more  
5 importance that we need to be focused on than  
6 correct records. Unless there's some evidence  
7 that this is a rampant problem that needs fixing,  
8 I don't know, you know, what the evidence is. So  
9 how could you be so excited? You must have  
10 evidence that this is like a plague infecting the  
11 EHR system across the country.

12 MS. ANDERSON: I -- it was just a  
13 pretty straightforward calculation that had  
14 enough points. So there is -- it's a risk-  
15 adjusted outcome measure that crosses many  
16 different settings. And so -- and it uses  
17 electronic clinical data that didn't have a lot  
18 of burden for reporting.

19 So that, that is the rationale behind  
20 the staff preliminary analysis. And I'm not  
21 hearing a nomination to include it into the  
22 family of measures.

1 I'm not hearing a nomination to  
2 include the others either, so barring none --  
3 barring any, we can move on and we will do our  
4 work as staff to investigate the other two  
5 measures like this to bring forward for your  
6 consideration and inclusion in the family in the  
7 morning.

8 We will conduct a brief break. We  
9 will make sure that our next presenter is on the  
10 phone, and we will talk about a person- and  
11 family-centered care NQF endorsement project  
12 next.

13 So I would ask you all to return to  
14 your chairs at 3:30, and that's it. You get a  
15 break. Thank you.

16 (Whereupon, the above-entitled matter  
17 went off the record at 3:17 p.m. and resumed at  
18 3:30 p.m.)

19 CO-CHAIR HANSEN: So, we are actually  
20 going to move into the whole area of person-  
21 centeredness that has been an important focus for  
22 our MAP, and this is one of those examples where

1 we have the opportunity to get cross-  
2 fertilization.

3 So, there is some recent new measures  
4 that have come out from this MAP group, and we're  
5 really happy to have our colleague here have a  
6 chance to speak.

7 And we are, I guess, going to have  
8 Sarah Sampsel. Okay, Sarah, I think I hear you  
9 on the line.

10 MS. SAMPSEL: Yes. Thank you. Hi  
11 everybody. My name is Sarah Sampsel. And I am  
12 calling in from New Mexico where I can typically  
13 report it's sunny and 70, but we've had a lot of  
14 rain lately. So, I can't even report that.

15 I am the Senior Director for the  
16 person- and family-centered care work, as well --  
17 and so that is endorsement and consensus  
18 development project work or CDP project work. As  
19 well as the Senior Director for the MAP PAC/LTC  
20 Workgroup.

21 So, kind of a lot of cross-  
22 pollination, fertilization as was just mentioned.

1 So, what I'm going to do is provide a quick  
2 overview and update of the work of the person-  
3 and family-centered care standing committee.

4 Which has been back up and running  
5 since about 2013. It's a really active committee  
6 because there's a lot of interest in this area  
7 and I'll provide an update on where we are in the  
8 measure portfolio and some kind of key themes  
9 that we're hearing from the group.

10 But also realize that it's kind of  
11 hard to put two phases of work into just a couple  
12 of slides. But we're seeing some really exciting  
13 activity on the endorsement, both measure  
14 development and measure implementation side when  
15 it comes to first person- and family-centered  
16 care measures.

17 So, if we can go to the next slide.  
18 I thought it would be important to center  
19 everybody on the fact that NQF had a project a  
20 few years ago. I think it was in 2011/2012,  
21 where they pulled a panel together to formulate a  
22 kind of broad-based definition on what is person-

1 and family-centered care. And specifically  
2 ensuring that there's alignment with the National  
3 Quality Strategy.

4 So, our definition is an approach to  
5 the planning and delivery of care across settings  
6 and time that is centered on collaborative  
7 partnerships among individuals, their defined  
8 family and providers of care.

9 It supports health and well-being by  
10 being consistent with respectful and responsive  
11 to an individual's priorities, goals, needs, and  
12 values.

13 And so, you know, that's fairly broad-  
14 based. It's extremely crosscutting. You all  
15 have seen measures in other areas such as health  
16 and well-being, care coordination, et cetera that  
17 certainly could fall into this bucket as well.  
18 And so, as I go through the projects, you'll see  
19 we did some further, almost refinement of the  
20 type of measures that come through our portfolio.  
21 Next slide.

22 So our first phase was in 2014 and

1 finished up in 2015. In fact, very -- pretty  
2 early last year so that we could start our second  
3 phase, and in this first phase we recommended  
4 endorsement maintenance of ten measures, both  
5 maintenance and new measures. These were all  
6 focused on experience of care.

7 And so -- and I know in the past  
8 section, or two sections ago, you were talking  
9 about some measures that have had changes in  
10 endorsement status and that included some of the  
11 CAHPS measures.

12 And that was because of some of the  
13 work that came out of this committee that those  
14 CAHPS measures were not put forward for  
15 maintenance review. Therefore, they ended up  
16 losing endorsement. And that was continued back  
17 and forth discussion with the developers at that  
18 time.

19 However, during that first phase, we  
20 did endorse ten measures. Which included  
21 hospital CAHPS, incidence of hemodialysis CAHPS,  
22 as well as the care transition measure, the CTM-



1 3, which should eventually be migrated into the  
2 overall hospital CAHPS measurement sets. And  
3 there were also some measures on patient  
4 experience of psychiatric care. And some  
5 measures regarding end of life and hospice care.

6 In this part of the project, we also  
7 identified some themes regarding gaps in the  
8 portfolio, and frankly, I'm sure these are also  
9 things that you all have discussed in the past.

10 But, specifically measures and surveys  
11 that they must be relevant and inclusive of  
12 populations that speak languages other than  
13 English. So, how is that translated in a CDP  
14 project?

15 Well, this standing committee asked a  
16 lot of questions about the number of formats a  
17 survey may be available in if we're deriving  
18 measures from it and the level of testing if a  
19 measure developer comes forward and says it's  
20 translated into 43 languages.

21 Well, did the measure -- or do the  
22 questions and the items on the questions mean the

1 same? So that you would actually have valid and  
2 reliable measures when you report out those  
3 measures for top line scoring. Which a lot of  
4 these survey-based measures do.

5 Measures should be developed for other  
6 care settings including rehabilitation  
7 facilities. And remember this is specifically  
8 feedback on experience of care measures. And at  
9 that point, hospice CAHPS had not come through  
10 NQF. In fact that's currently under  
11 consideration by the palliative care project.

12 But, we were still seeing a lot of the  
13 CAHPS and experience of care level measures  
14 focused on facilities, whether it be psychiatric  
15 or acute care. You know, the end of -- I'm  
16 sorry, incident hemodialysis care. Again, it's a  
17 facility-based measure. Although it is a  
18 dialysis facility versus necessarily a hospital.

19 And so really kind of encouragement  
20 from the person- and family-centered care  
21 standing committee that they'd like to see these  
22 settings expanded and CAHPS measures -- or other

1 expansive care measures that are updated for  
2 other settings.

3 And then a need to -- there is a need  
4 to better understand commonly excluded  
5 populations and how their voices may not be heard  
6 across surveys.

7 So, for example, in I believe it's  
8 hospital CAHPS, maternity patients are excluded.  
9 And there was concern raised about that because  
10 obviously in a certain percentage of the female  
11 population, especially during the fertile age  
12 period, that might be the only reason a woman  
13 ends up in the hospital. So, we're missing all  
14 of that information. As well as -- you know,  
15 consideration of pediatrics.

16 And in a recent pediatric CDP project  
17 as well, there were a lot more expansive care  
18 surveys that came forward. So, I think we're  
19 slowly seeing these gaps being filled.

20 If we can move on. So, in phase two  
21 of the project, and we just submitted our final  
22 report on phase two, we actually looked at 28

1 measures and all of these measures were focused  
2 on functional status. We had a suite of measures  
3 from FOTO, which is the Focus on Occupational  
4 Therapeutic Outcomes.

5 And the FOTO measures were really  
6 about improvement in change score on functional  
7 status for patients with specific ailments.  
8 Typically, I think there was lumbar. There was  
9 neck and spine in addition. There were general  
10 orthopedics. There was hand and wrist. There  
11 was ankle. But basically, certain areas that  
12 might -- that showed some variation in how  
13 functional status changes over time with  
14 treatment.

15 We also saw the CARE Item process and  
16 outcome measures. So, as you may be familiar  
17 with, CMS has recently and over the past few  
18 years been working on the CARE assessment tool,  
19 and out of that they stated to develop measures.  
20 And some of these were setting-specific measures,  
21 whether they were for long-term care or inpatient  
22 rehabilitation facilities.

1                   And then UDSMR submitted some measures  
2                   that were derived from the FIM. Again, focused  
3                   on self-care, mobility and overall motor skills  
4                   for patients in specific long-term care settings.

5                   So, with those first two phases, the  
6                   table at the bottom of this slide just shows that  
7                   currently we have 11 process measures and 59  
8                   outcome measures in this portfolio.

9                   You know, I can't make any extreme  
10                  predictions on what's going to happen. I can  
11                  tell you in phase three of the project that our  
12                  submission deadline just closed a week or two  
13                  ago.

14                  We have an additional 21 measures for  
15                  review, which will expand the portfolio a little  
16                  bit more. There are only nine measures up for  
17                  maintenance review, and another 12 new measures.

18                  And we'll be seeing some measures come  
19                  forward with things like shared decision-making.  
20                  We're currently in the process of finalizing  
21                  endorsement and ratifying a measure on patient  
22                  activation.

1           We have a lot of communication  
2       measures coming forward. And then we have some  
3       more FIM-based measures coming through this next  
4       cycle. So, the portfolio is continuing to  
5       expand. We're certainly seeing this to be an  
6       important area. Next slide.

7           So, in phase two, as I went back  
8       through the report and was thinking about, you  
9       know, kind of what you all would want to hear and  
10      what might be relevant to you, we did have some  
11      themes that came out of that report.

12          One of those has to do with parsimony  
13      in functional status measurement. And you know,  
14      we heard about -- we also heard that through the  
15      PAC/LTC workgroup as well, in that, you know,  
16      there's a strong need for measure alignment.

17          And in order to do so, then you really  
18      want the measures and the assessment tools that  
19      you're using to align across settings. So that's  
20      -- you know, that's one of the goals that we see  
21      coming across, and certainly with the measures  
22      that were submitted to us by CMS.

1           There is -- there was the need and  
2 continued need to acknowledge as new measures and  
3 new assessment tools are brought forward and even  
4 though they may have very good intent on  
5 improving measurement science, or improving  
6 assessment science, et cetera, there has to be  
7 some reflection and consideration given to the  
8 fact that some of these facilities, specifically  
9 the PAC/LTC facilities, have been using one tool  
10 for a long period of time.

11           And realizing one, you know, it's a  
12 switch in staffing. There is incredible  
13 training. There may be some financial  
14 implications as well, but it's not just a simple  
15 switch over from one measure to another or one  
16 tool or another. And some consideration to that  
17 in the process.

18           And then finally thinking about a  
19 common core set of items that could be used  
20 across settings. And so, there's a lot of  
21 discussion about the fact, especially with the  
22 FOTO measures, which was a series of seven

1 measures looking at seven different parts of the  
2 body, and joint areas of the body.

3 You know, is it really necessary to  
4 have a different assessment tool for each? And  
5 there's some pliant space to say that perhaps  
6 there is.

7 Perhaps you really do need one  
8 assessment for the back and a different for the  
9 knee, you know, in order to get to the right  
10 components of functional status, but I think all  
11 of that's still, you know, that's work outside of  
12 NQF. But certainly strong considerations that  
13 the standing committee brought forward and wanted  
14 documented in the report. Next slide.

15 So what I wanted to do now is quickly  
16 transition because both the person- and family-  
17 centered care work, as well as the PAC/LTC work,  
18 and then some of the measures that you have been  
19 considering and will be considering as we move  
20 forward, are kind of outcomes of the IMPACT Act.

21 And I can't say that I do this part of  
22 the presentation as well as my CMS colleagues.



1 But, I do think this is important for you to  
2 understand and have this background of, you know,  
3 that's why we had 28 measure in phase two.

4 That's why we'll have additional  
5 functional status measures coming through phase  
6 three of person- and family-centered care. And  
7 I'm sure more to come because we certainly saw  
8 additional ones coming through on the MUC list  
9 for PAC/LTC last year.

10 But basically, it's the Improving  
11 Medicare Post-Acute Care Transformation Act, or  
12 the IMPACT Act of 2014. So, it was signed on  
13 October 6, 2014, and with the goal of  
14 standardized patient assessment data that will  
15 allow uniformity, the ability to capture quality  
16 care and improve outcomes. The ability to  
17 compare quality data across post-acute care  
18 settings. To increase focus on discharge  
19 planning. Exchangeability of data, and  
20 coordinated care.

21 When I look at this full list, these  
22 all work hand in hand. And there's not one of

1       them is a unique characteristic in and of itself.  
2       You know, I think it's really important to  
3       acknowledge and understand that you really can't  
4       have improved discharge planning until you have  
5       that exchangeability of data and the coordination  
6       of care.

7               And so, as we've been looking at these  
8       measures and considering these measures through  
9       the CDP project, those are some of the things  
10      that we have to think about. Is okay, what is  
11      this doing to meet those intents, or meet that  
12      intent? And how does it all work together? Next  
13      slide.

14             You know, and I think some of this is  
15      a little bit, you know, even it takes us back to  
16      the next slide a little bit. In that there are  
17      driving forces of the IMPACT Act. And so, some  
18      of those forces included improving Medicare  
19      beneficiary outcome. There has been a lot of  
20      talk over the past few years, and actually --  
21      there's been a considerable amount of action too,  
22      that tries to improve discharge planning, that

1 tries to improve transitions of care. And  
2 really, all of that was the intent to improve  
3 Medicare beneficiary outcomes.

4 There's also this need for provider  
5 access of longitudinal information to facilitate  
6 coordinated care. And with that, if you're  
7 measuring functional status at discharge from a  
8 hospital and using that same tool and able to  
9 compare the data from discharge to the hospital  
10 to say an inpatient rehabilitation facility and  
11 to home health, that's huge.

12 You can really see the trajectory of  
13 a patient and see where there might be some areas  
14 where you need to -- you know, where the  
15 providers either need to go back and find out  
16 more about what worked and didn't work in the  
17 past, or how the treatment plan may change in the  
18 future.

19 We've already mentioned enable the  
20 comparable data across -- comparable data and  
21 quality across PAC settings. And all of these, I  
22 think, lead into that improved discharge planning

1 and then research.

2 And you know, I think in the work that  
3 we do with our CMS colleagues, working on the  
4 implementation of the IMPACT Act, and  
5 specifically the development of measures and  
6 implementation of assessment tools, you know,  
7 that really is something that they're  
8 continuously learning from.

9 That there's not this, okay, we did it  
10 and now let's stop. It's a continual process of  
11 not only monitoring the measure, but monitoring  
12 how it's working in the field and is it really  
13 leading to improved outcomes.

14 You know, I think the attention on  
15 post-acute care and the attention on why the  
16 IMPACT Act is getting so much attention, is  
17 really tied up in the escalating costs. And the  
18 fact that there really is a lack of  
19 interoperability across PAC settings.

20 And I think that you all have been  
21 challenged with that with some of the measures.  
22 And I listened to part of your last conversation,

1 and even talking about medication reconciliation  
2 or pressure ulcers, and where is it most  
3 important, in a hospital or a home health, or  
4 where?

5 Well, wouldn't it be great if we all  
6 had the same measures and the same tools to  
7 assess that type of thing? That we could share  
8 the data whether it was a hospital or home  
9 health? And I think those are some of the -- you  
10 know, that's the direction that we're seeing  
11 going for the future. Next slide.

12 So, I think this just really kind of  
13 -- you know, it was a really nice visual that we  
14 got from our CMS colleagues. That really kind of  
15 pulled this all together.

16 That in order to achieve the goals,  
17 such as reduction in provider burden, measures  
18 that follow the patient, assessment of quality  
19 across settings, you really do need data  
20 uniformity and interoperability.

21 And as we've seen measures coming  
22 through the person- and family-centered care CDP

1 process, that's really what we're seeing more of,  
2 is that overall intent and it's even a guiding  
3 principle that we're taking back to the standing  
4 committing and reminding them, you know, this is  
5 the reason why these measures are being put  
6 forward. This is the reason these measures are  
7 being evaluated, and this is the overall intent  
8 of being able to have and close that gap. So  
9 that there's the opportunity to use measures and  
10 tools across settings. Next slide.

11 And you know, again, I think just  
12 another summary slide that brings us all back to  
13 the fact that when you look at the IMPACT Act,  
14 you look at the work that the person- and family-  
15 centered care standing committee is doing. And  
16 then you look at the National Quality Strategy.

17 They kind of -- they all go hand in  
18 hand on strengthening person and family  
19 engagement. And really the only reason -- the  
20 only way -- some of the ways to do that would be  
21 promoting effective communication and  
22 coordination of care of prevention and treatment

1 of chronic disease. And that's really about  
2 looking at the whole person through their whole  
3 treatment setting, through their whole episodes  
4 of care versus isolated measurements. Next  
5 slide.

6 So with that, I think, Megan, I turn  
7 that back over to you. Unless there are any  
8 questions on the work of the person- and family-  
9 centered care committee.

10 MS. ANDERSON: That's correct. I am  
11 going to turn it over to my Co-Chairs to  
12 facilitate questions for you, Sarah.

13 CO-CHAIR HANRAHAN: Any discussion?  
14 Tom?

15 MEMBER LUTZOW: Well, the IMPACT Act  
16 is refreshing and this approach is promising, and  
17 you know, godspeed.

18 I've always frankly been disappointed  
19 with the IMPACT Act. I feel like chopped liver  
20 when I read the IMPACT Act. Nowhere in the  
21 IMPACT Act is there any mention of the role of  
22 managed care or the plan. Even though it is a

1 key measure weighted three times in the group  
2 that -- the five star group that grades managed  
3 care.

4 So, somehow it seems to me that since  
5 plans are also responsible for this measure, that  
6 they need to be at the table. As it's set up, it  
7 appears to be only provider-focused coordination.  
8 And because it doesn't include plans which now  
9 enroll 30 percent of the population or better, it  
10 may not include a key player.

11 So, as you develop measures, you know,  
12 if this has only a fee for service focus, fine.  
13 But, the fact of the matter is, plans are  
14 measured on readmission and they need to be at  
15 the table.

16 MS. SAMPSEL: Thank you. You know, I  
17 just want to comment on that because that's one  
18 of the things that the person- and family-  
19 centered care standing committee, that's some of  
20 the feedback that was provided to CMS in  
21 consideration of the measures related to the CARE  
22 Items Set, is that those are specific to



1 Medicare. And you know, while there's setting of  
2 care there, then you know, you include only  
3 Medicare patients.

4 And so that was some feedback that  
5 they'd like to see the population broaden and the  
6 ability to use the measure by other settings of  
7 care.

8 That I just think that was outside the  
9 scope of CMS for that development cycle.

10 CO-CHAIR HANRAHAN: Clarke?

11 MEMBER ROSS: Hi Sarah. This is  
12 Clarke Ross. I wanted to ask you a question  
13 about the charge of the person- and family-  
14 centered care committee. And if I'm correct,  
15 then ask you about timeline.

16 So, is this the National Quality Forum  
17 committee that's considering the Medicaid home  
18 and community-based experience survey?

19 MS. SAMPSEL: It is. And thank you,  
20 Clarke, for bringing that up. So that is one of  
21 the measures that's in phase three.

22 MEMBER ROSS: And then do you have a

1 timeline for the committee's considerations, CMS  
2 submission and then public comment?

3 MS. SAMPSEL: Yes. So, we have -- and  
4 actually that was really a nice segue of  
5 something I forgot.

6 So, the measure submission was March  
7 31. So, we have the measure in-house. We're  
8 currently CDP side in the completeness check and  
9 preliminary assessment phase.

10 And then in, I believe it's May 9 --  
11 and I'll have to get back and I can let Megan  
12 know when that is -- but we'll be opening that  
13 measure set up for pre-evaluation public comment.  
14 So, those will be any comments you want the  
15 committee to have during their in-person meeting.

16 And our intent was to notify not only  
17 this committee through Megan and Debjani, but  
18 also the home and community-based services  
19 committee that is -- or a workgroup that's within  
20 NQF as well. To be able to get you all the  
21 project alert when those measures are available  
22 and open for public comment pre-evaluation.

1           The standing committee meets in-person  
2     in D.C. on June 6 and 7. And then that report  
3     and their preliminary recommendations will go out  
4     for public comment, and I would assume that's  
5     sometime in mid to late June.

6           MEMBER ROSS: Thank you.

7           CO-CHAIR HANSEN: Sarah, this is  
8     Jennie asking a question relative to whether  
9     phase three is going to look at the gap area or  
10    begin to document the gap area of pulling out  
11    really what matters to the person?

12           I know this is kind of the -- you  
13    know, the new areas because of the ability to  
14    make sure that that is part of it as the patient-  
15    and family-centered care side of it too.

16           Currently none of our measures more or  
17    less will capture that element. So, here we have  
18    outcomes that we think, you know, professionally  
19    should be able to be achieved, but how does that  
20    copacetically align with what matters to the  
21    person?

22           MS. SAMPSEL: Oh, that's such a good

1 question. You now, yes. In some, there will be  
2 a couple of opportunities.

3 And in all honesty, we've already  
4 heard that from the committee. We heard that --  
5 and my phases start getting confused, but I  
6 believe it was in phase two that we had some  
7 discussion with the committee kind of off the  
8 record. So, it wasn't transcribed.

9 But, kind of what do they want to see?  
10 And what would really make a difference for them?  
11 And that really was about that integration of,  
12 okay, you say these measures are person- and  
13 family-centered care, but what do we know from  
14 the patient?

15 And so, you know, that conversation  
16 started with experience of care and we're seeing  
17 the committee push on that more and more and  
18 being able to put in our report the documentation  
19 of that push.

20 And I think there's going to be some  
21 opportunity to even further that conversation  
22 because we have two measures coming through this

1 third phase of work.

2 One is on the shared decision-making  
3 process and then the other has to do with --  
4 again, with informed consent, shared decision-  
5 making, and the level of knowledge of patients  
6 for elective surgeries, specifically in knee and  
7 hip replacement.

8 So, you know, so that conversation  
9 will happen as part of those measure reviews.  
10 Those are measures that have been submitted by  
11 Jack Staller from Healthwise and Karen Sepucha  
12 from University of Massachusetts.

13 And then the other thing that I will  
14 just mention here is NQF -- and you can find this  
15 information on our website -- was funded by the  
16 Moore Foundation to do some work on shared  
17 decision aids.

18 And we're still kind of fleshing out  
19 what that looks like, but we've put together an  
20 expert panel that will convene also in June to  
21 talk about, you know, what would a shared  
22 decision aid certification process look like

1 where we'd be certifying the shared decision  
2 aids. And ensuring we have that patient value  
3 feedback, et cetera, as part of the decision aid  
4 certification?

5 Which is why we have people such as  
6 Karen Sepucha on the committee. Who feel very  
7 strongly about that portion of it.

8 So, I think we're getting closer and  
9 closer to having, you know, kind of concrete  
10 discussions about that gap and how we integrate  
11 it into our criteria, but, you know, I still  
12 think there's work to do.

13 CO-CHAIR HANSEN: Thank you, and I  
14 hope that some of the work that's happening at  
15 NCQA on their measure development with the grant  
16 from the SCAN Foundation is a part of that as  
17 well.

18 MS. SAMPSEL: I wasn't aware of that,  
19 but I can certainly follow up since they are my  
20 former employer.

21 CO-CHAIR HANSEN: Okay. Thank you.  
22 Charlie?

1                   MEMBER LAKIN: Thanks. Thanks Sarah.

2       You know, I read your definition with interest  
3       and noticed that -- I wasn't too enthusiastic  
4       until I got to the very last phrase that said  
5       respectful of and responsive to an individual's  
6       priorities, goals, needs, and values.

7                   And you know, I think that's really  
8       what it's all about. People having control and  
9       choice and independence and relationships and  
10      self-determination, and for the 40 percent who  
11      are under 65, employment and housing. And I just  
12      didn't see those themes coming out as strongly in  
13      your presentation as I think they're felt by the  
14      people who are really interested in having  
15      person-centered and family-centered care.

16                  And so, it sounds like you're really  
17      listening to people, but you're going to get an  
18      earful when you do, about the differences between  
19      what they can expect and what they're getting.  
20      Or what we would hope they might get -- what they  
21      would hope they would get and what they're  
22      getting.

1           So, you know, and even issues like  
2       shared decision-making. I think you get a lot of  
3       push-back from people about whether the decisions  
4       that affect their lives deeply are ones they  
5       really want to share equally with people and ones  
6       they really want to control personally.

7           So again, I'm excited about the title  
8       of this MAP. I do hope it can really listen  
9       carefully to people. The same people that sort  
10      of shape the HCBS regs, which I think are very  
11      forward looking, and also a lot of the people who  
12      speak quite lively on the HCBS NQF committee.

13           MS. SAMPSEL: Yes. You know, and I'll  
14      just comment on that. We had a few open slots on  
15      the person- and family-centered care standing  
16      committee and we focused really heavily on  
17      ensuring that we had more patients and caregivers  
18      on the committee that, you know, we have  
19      representation from MDs and OTs and nurses, et  
20      cetera. That we really wanted to do some strong  
21      patient focus.

22           So, we really beefed up the committee



1 on that respect in order to get more of that  
2 information out. And NQF, you know, it's  
3 challenging for us because then that means, you  
4 know, we may have people on our committees that  
5 don't understand reliability, validity, et  
6 cetera, but do patients' care.

7 And then, you know, I think the other  
8 piece that I'll mention on that, that's exactly  
9 one of the reasons why we want to ensure with  
10 this next phase of work that we notify both this  
11 group as well as the HCBS NQF Committee, that  
12 these measures are out for comment.

13 And I agree. We're going to get a lot  
14 of comments. We got a lot of comments in phase  
15 two. I think the most comments NQF has ever  
16 received, and we know it's important. And I  
17 think, you know, I would even say our definition  
18 of person- and family-centeredness and how that  
19 is interpreted under the criteria will most  
20 likely evolve over time.

21 CO-CHAIR HANRAHAN: Thank you.

22 MS. ANDERSON: Thank you, Sarah. This

1 is Megan. We are going to start the review of  
2 the measures that have been newly endorsed under  
3 this project and we thank you so much for your  
4 presentation. We hope that you can stay on the  
5 line to answer any additional questions, but  
6 understand if you have other obligations.

7 MS. SAMPSEL: No. I'll stay on,  
8 Megan.

9 MS. ANDERSON: Great, thanks. So, we  
10 are on slide 108 for those who are on the phone  
11 or elsewhere. And we're going to move on to  
12 slide 109 which lists 12 newly endorsed measures  
13 for consideration.

14 If you recall, we already discussed  
15 two measures that were not considered really the  
16 best in class for the population, and those were  
17 2643 for lumbar spine and 2653 for total knee  
18 replacement. They were considered condition-  
19 specific and did not address the workgroup  
20 priorities.

21 So, in front of you, you have 12 newly  
22 endorsed measures for person- and family-centered

1 care project and we'll consider them one by one.

2 I'm going to go through each of them  
3 and pause for questions at the end. And based on  
4 that, at the end of this presentation, we will  
5 ask workgroup members to nominate a measure for  
6 inclusion in the family, if any at all.

7 Any questions?

8 (No response.)

9 MS. ANDERSON: Okay. Moving right  
10 along to 2287: Functional Change: Change in Motor  
11 Score.

12 This is a change in risk scored  
13 derived values of motor function from admission  
14 to discharge among adult inpatient rehabilitation  
15 facility patients aged 18 and older who are  
16 discharged alive within 12 -- and the time frame  
17 of the measure is 12 months.

18 It includes specific FIM items. And  
19 they are feeding, grooming, dressing upper body,  
20 dressing lower body, toileting, bowel,  
21 expression, memory, transfer bed, chair,  
22 wheelchair, transfer toilet, locomotion and

1 stairs.

2 It's a risk-adjusted outcome measure  
3 and it's classified for inpatient rehabilitation  
4 facilities.

5 The staff preliminary analysis  
6 consider it an addition to the family because it  
7 addresses high leverage measurement opportunities  
8 for quality of life and priority area in optimal  
9 functioning, and any questions about this  
10 measure?

11 MEMBER ROSS: This whole list of  
12 measures in some way seems to be contradictory to  
13 the purpose of the IMPACT Act, which is a single  
14 assessment, a single measure across facility and  
15 provider types.

16 And yet we're being asked to consider  
17 motor scores and inpatient rehab facility for  
18 patients between the ages of 18 -- or over the  
19 age of 18 and then each one is going to be  
20 setting specific.

21 And I know the expertise of the post-  
22 acute care and long-term care committee are

1       predominantly the four provider types.

2               But, this whole host just seems to  
3       perpetuate distinct provider types rather than  
4       making more significant progress in applying the  
5       same motor score across nursing homes, post-acute  
6       care settings, inpatient rehab settings, and home  
7       healthcare settings.

8               So, I'm already uncomfortable with the  
9       whole list because it's setting specific and the  
10      IMPACT Act's intent is to boldly go where we  
11      haven't been before across settings.

12              MS. ANDERSON: We don't have authority  
13      to make recommendations about the IMPACT Act.  
14      We're here to make recommendations to CMS and the  
15      Center for Medicare and Medicare Coordination  
16      Office.

17              We do have a representative on the  
18      phone still if they -- if you have a question  
19      specific to them. I think your point about this  
20      being a single setting measure is very valid.

21              However, it is not included at this  
22      time in IMPACT Act measures or any federal

1 programs. When a measure is included in a  
2 federal program, we will list that as well.

3 CO-CHAIR HANRAHAN: Michael? Or I'm  
4 sorry, Marcia.

5 DR. WILSON: Sarah, I think you're  
6 still on the phone. This is Marcia, and I'm  
7 going to start an answer, but please correct me  
8 if it's not correct.

9 I think part of what you're seeing,  
10 Clarke, is when a measure's brought forward for  
11 endorsement, the setting is specified. And so  
12 for example, some of these measures, I believe,  
13 Sarah, if I'm remembering correctly, had only  
14 been tested in the inpatient rehabilitation  
15 facility setting.

16 But the measure developers were very  
17 clear, is they intended to test them in further  
18 settings. So, I think, in part -- not the whole  
19 list. It doesn't explain the whole list, but I  
20 think in part, what you're seeing Clarke, is the  
21 beginning of a measure tested in one setting.  
22 With the intent to expand it to other settings.

1 Sarah, is that a fair statement for  
2 some of the measures?

3 MS. SAMPSEL: To some degree. What I  
4 want to delineate is the fact that the use of the  
5 word measure -- and so the FIM historically, and  
6 I believe has been fully tested and vetted in use  
7 across settings.

8 When we come down to the performance  
9 measure, which is under NQF's purview, so 2287,  
10 2286 and 2321, those are the performance  
11 measures. And those were only put forward to us  
12 for the specific setting of inpatient  
13 rehabilitation facility.

14 And then so, you know, where I would  
15 say there are similarities is the CARE Item Set  
16 and the FIM item set are both, you know, as  
17 functional measures, are applicable to multiple  
18 settings.

19 When it came to the performance  
20 measures, those were submitted to us as Marcia  
21 said, on the endorsement side for specific  
22 settings.

1 DR. WILSON: Thanks for the  
2 clarification, Sarah.

3 MEMBER MONSON: So, this maybe just a  
4 -- this may be a total wrench, but, you know  
5 what? It's interesting because when I think  
6 about functional, I think about ADLs. Which  
7 clearly are -- some of them are listed here.

8 But, I don't think about them from a  
9 rehab/FIM perspective. And if -- I might be over  
10 my -- excuse me, but I'm pretty sure a FIM has to  
11 be done by a physical therapist or an  
12 occupational therapist. I don't think --

13 MS. SAMPSEL: That's correct.

14 MEMBER MONSON: So, there is a part of  
15 me that says -- you know, and I know that you  
16 started on post-acute. But, those same ADL  
17 measures, we're going to want to measure for  
18 Medicaid beneficiaries in the community and in  
19 long stay settings and facilities as well.

20 And is there benefit then to be  
21 thinking about how we actually measure ADLs that  
22 doesn't require a clinician to make that



1 measurement?

2 CO-CHAIR HANRAHAN: I'm still not  
3 really quite understanding Clarke, what you're  
4 trying to point out and I want to.

5 MEMBER ROSS: I'm trying to point out  
6 that there is a theme within the National Quality  
7 Forum to have fewer measures than more measures,  
8 and at the same time, we have 12 measures that  
9 are distinct to specific settings.

10 And the IMPACT Act's entire purpose is  
11 to have single measures and -- start it with  
12 assessment, but single data and single measures  
13 across settings so that wherever you go as an  
14 individual person, you have the same expectation,  
15 the same data, and the same assessment. And this  
16 seems to just contradict that.

17 And meanwhile, there's this -- we've  
18 got to have fewer and fewer measures. And yet,  
19 we want to add 12 that -- or consider adding 12  
20 that are, again, distinct to one setting.

21 And I'm sure each of these has value.  
22 It's just why -- and the answer I heard was

1       because measure developers and each of the  
2       associations of these providers have these.

3               But how do a consumer representative  
4       think about and deal with and vote on this  
5       dynamic? Which I just -- I think this is the  
6       wrong direction to go, and yet you can justify  
7       the importance of each of the 12 areas to be  
8       measured.

9               MS. SAMPSEL: So Clarke, Marcia and I  
10       are arguing online who should answer the question  
11       for you. But, I'll just comment on that because  
12       I think it's a really important conversation for  
13       you all to have and for us to get this feedback  
14       on. And I think, you know, Megan and Debjani  
15       would agree that it's, you know, kind of getting  
16       there on the table is important for NQF for  
17       documentation purposes.

18               And that doesn't differ from  
19       conversations that we're having on the  
20       endorsement side. So on the CDP side, where  
21       there really is a hope and a try, I would say, to  
22       get standing committees to think about the

1 overall portfolio and do we need 12, and frankly  
2 I would envision there's probably a good 20 more  
3 functional status measures that their only  
4 difference is setting of care, where the tool is  
5 the same across settings.

6 And when it comes to the performance  
7 measure and number of actual performance  
8 measures, it gets to the conversation of okay, so  
9 which is the best performance measure?

10 And, you know, on the endorsement side  
11 what's brought to us would be the testing of how  
12 these performance measures play out, how they  
13 contribute to quality of care, and when you play  
14 instrument against instrument, there's obviously  
15 a lot more data in an instrument such as the FIM  
16 that's been out for 25 years, versus the care  
17 tool, which has been tested, which is being  
18 solely implemented, but frankly there's not  
19 enough data to say whether that's a good -- that  
20 tool's better than the FIM, et cetera, although  
21 obviously that's the hope.

22 But it raised a level of discomfort

1 even on the endorsement side to be able to say  
2 this measure is better than this measure. So,  
3 this is kind of back to I feel like a theme I  
4 said earlier, that this is an area of more to  
5 come where we need to listen to you all.

6 I think this really plays into part --  
7 you know, what do patients and, you know, persons  
8 and caregivers want on this side as well? We're  
9 considering burden and how does this all play  
10 out, and how do we bring all this information  
11 together to not only bring back to groups such as  
12 the duals group, but the PAC/LTC, the overall MAP  
13 considerations, and then the endorsement process  
14 as well.

15 So it's not an easy answer but what we  
16 will say is that it's a consideration and it was  
17 also a level of challenge on the endorsement  
18 side.

19 MEMBER CHALK: So if we were to  
20 approve these, endorse them rather, what's the  
21 incentive of going to what Marcia said earlier?  
22 What's the incentive for a developer to take it

1 to then test in the all the other settings to  
2 make this an across-setting measure?

3 You said, you know, more to come.  
4 Maybe they'll test it in other settings. What  
5 direction is NQF able to give a developer, if  
6 any, about, this isn't where measurement's going?

7 It's not going setting by setting, and  
8 it's incumbent upon you, if you want to get our  
9 endorsement, to test it across settings and come  
10 back when you're ready.

11 DR. WILSON: This is Marcia. I would  
12 say that measure developers have already signaled  
13 to us that that is exactly what they want to do.  
14 And it's not so much NQF driving this, it's the  
15 IMPACT Act and where CMS wants to go.

16 MEMBER CHALK: But, that doesn't show  
17 up in the measures that you're asking us to  
18 endorse.

19 DR. WILSON: That's right, and because  
20 of what Sarah said, it's -- I don't want to say  
21 it's a temporary situation but it is somewhat a  
22 temporary situation where you have a -- say an

1 instrument like FIM that's been in use for a long  
2 time, CMS has developed the care tool.

3 And in bringing both of those forward,  
4 it was -- the committee was unable to say this is  
5 the best in class in terms of the measure, and so  
6 what happened is we asked for more time to let  
7 the care tool be tested.

8 We've had discussions with CMS and the  
9 developers of the measures from the FIM tool, and  
10 then the developers from the CMS care tool,  
11 brought them all together and say, we're going to  
12 watch this and come back at a point in time to  
13 see what happens.

14 So I see this as an interim step to  
15 getting to where we want to go. But it does, I  
16 will admit, it poses a dilemma for this workgroup  
17 right now at this point in time.

18 CO-CHAIR HANRAHAN: Go ahead Tom.

19 MEMBER LUTZOW: Yes. I'm getting the  
20 sense that CMS needs these endorsed to create an  
21 environment for them to move ahead. If I'm  
22 wrong, that's fine.

1           The assumption is that achievement of  
2   high scores in each one of these measures somehow  
3   serves the purpose of readmission prevention.

4           And do we have evidence that that is  
5   the case? Or are we simply creating an  
6   environment where that will be perfected later,  
7   but now CMS can move ahead because NQF has  
8   created an endorsement set that serves as a  
9   foundation for them to act? I mean, is that what  
10   we're talking about?

11           MS. ANDERSON: Well, from a --

12           MEMBER LUTZOW: So, I have two  
13   questions. Does CMS need us to do this for other  
14   reasons, to build an assessment program that  
15   serves the purpose of readmission prevention?

16           And then do we have evidence that this  
17   truly does serve to strengthen readmission  
18   prevention?

19           MS. ANDERSON: Some measures that are  
20   in front of you from the person and family-  
21   centered care project are primarily related to  
22   functional status. And they are elevated to this

1 discussion and this intensity because it is a  
2 priority gap area that this workgroup has voted  
3 as a priority.

4 And so optimal functioning is one of  
5 the highest priorities from this workgroup's  
6 perspective. CMS has not asked, and this is not  
7 part of our contract with CMS, is their funding  
8 to review these measures other than in to  
9 maintain the family of measures.

10 And that the work today is not  
11 directly related to input on the IMPACT Act and  
12 federal programs for post-acute long term care  
13 settings. It is directly related to the dual  
14 beneficiary population, which happens to also  
15 have a high utilization rate of post-acute and  
16 long term care settings.

17 So, I don't know the -- I think  
18 there's probably somebody who's smarter about  
19 functional status measures and readmission. But  
20 these measures are about functional status, and  
21 we're not being -- we're not under any directive  
22 from CMS to look at these measures.



1                   And if you -- if the workgroup does  
2                   not think any of them should be included in the  
3                   family, none of them need to be included in any  
4                   way.

5                   MEMBER LUTZOW: Yes, in my view, the  
6                   concern here, and the specific reason the duals  
7                   are at a little bit of at a disadvantage on  
8                   readmission prevention, I would guess the rate is  
9                   higher, I'm sure it is higher with duals, is  
10                  really the home environment.

11                  You have infection control issues,  
12                  hygiene control issues, fall risk control issues  
13                  that are really part of their domestic  
14                  environment. And that environmental assessment  
15                  and correction is where some of the major work  
16                  has to be done for us to bend that curve.

17                  So, you know, getting to that home  
18                  environment and supporting a correction there, is  
19                  kind of a key intervention strategy here. So,  
20                  that part seems to be missing.

21                  MS. ANDERSON: So I think you're going  
22                  to hear tomorrow from one of our colleagues from

1 NQF about the home and community service project  
2 and the environmental scan that's been conducted  
3 and input from that committee.

4 We're also going to have a significant  
5 focus tomorrow afternoon on community integration  
6 connection to community resources, which is  
7 strongly related to things in the home that  
8 you're talking about.

9 So that would be things we can look  
10 forward to tomorrow, though I definitely  
11 understand the connection to the functional  
12 status measures that are in front of us, and  
13 readmission rates and the importance of the home  
14 environment.

15 And so, this is really interesting  
16 conversation. I think that we'll continue to  
17 hear it and it will be one of the primary themes  
18 for our report.

19 CO-CHAIR HANRAHAN: I'd like to add to  
20 something Michael said that I wouldn't have  
21 identified. But, I think his -- as problematic  
22 as this being site sensitive or specific is the

1 FIM being only valid if used by a physical  
2 therapist. And I think you said it too, Clarke  
3 that you know, if it's provider centric, and the  
4 measures are provider centric, how does that move  
5 this agenda forward?

6 The other is, you know, I think many  
7 of us are familiar with the MDS, which is a great  
8 data system and a database that measures  
9 functional ability very well, and we've got huge  
10 longstanding data for good comparison and good  
11 risk adjustment and et cetera, et cetera. Has  
12 the MDS been considered? And why the FIM? I  
13 know why the FIM. It's got probably some  
14 validity studies that make it endorsable, but --

15 MS. ANDERSON: We're going to see some  
16 MDS measures that are related to the care tool  
17 next, but I think we have one more question  
18 related to this conversation and then we can move  
19 on to discuss the care tool measures and that MDS  
20 data. Does that make sense for the workgroup?

21 Okay. Alice?

22 MEMBER LIND: Actually I was just

1 going to say, could we go back to the long list  
2 and just focus on the couple that you picked?  
3 And skip -- not go through in such detail all the  
4 ones that you don't really like? So -- but you  
5 didn't really prioritize the care ones either.

6 MS. ANDERSON: It's not that I didn't  
7 like them. It's that --

8 MEMBER LIND: Well, the fit. I mean,  
9 right? You were looking at them for fit. And  
10 it's like it -- I mean, I'm just thinking if  
11 Thomas and Clarke both don't like FIM measures,  
12 let's just get to the ones that you think there's  
13 any promise of us choosing and not belabor it.

14 MS. ANDERSON: With all of these  
15 measures, they are new measures. They're newly  
16 endorsed, and most of them are newly developed in  
17 any way. And so, we have a challenge with any  
18 experience with these measures. And so, there --  
19 it's hard to bring anything to the top.

20 And so, from the staff analysis  
21 perspective, it could not weigh any of the  
22 measures -- hardly any of the measures above

1 others, except for those that truly rose to the  
2 top. And there is a specific challenge in  
3 weighing care tool measures over the FIM measures  
4 because of the newness of them. And so -- and of  
5 the comparability. The standing committee  
6 couldn't pick them so, as staff, I'm having a  
7 hard time also picking.

8 So, are others in favor of looking at  
9 the staff picked measures 2624, functional  
10 outcome assessment, and 2631, percent of long  
11 term care hospital patients with admission and  
12 discharge functional assessment and care plan  
13 that addresses function?

14 Are you interested in looking at those  
15 two in isolation? And waiting for more use data  
16 and information -- experience information about  
17 the other measures before recommending them for  
18 use in dual beneficiary populations?

19 I'm seeing a lot of nodding heads. We  
20 have one more question. Michael?

21 MEMBER MONSON: Actually it's a comment  
22 more. Which is under -- I would -- I understand

1 where these new measures came from. I would  
2 recommend we not spend a lot of time on EARTH and  
3 LTC measures. Only because they're dinosaurs  
4 that -- you know.

5 And the way the policy environment is  
6 going -- and not that there's not a place for  
7 them, but there's not going to be a lot of place  
8 for them actually with the way the policy and  
9 payment environment is going.

10 So, spending a lot of time figuring  
11 out measures for settings that are effectively  
12 going to be far and few between if existing at  
13 all, it doesn't seem necessarily like the best  
14 place for us to spend our time.

15 MS. ANDERSON: Okay.

16 MEMBER ROSS: I'd just like to  
17 reinforce that site-neutral payment is a big  
18 issue pushed by Congressional committees and  
19 MedPAC and people within CMS, and so each of the  
20 distinct provider groups are resisting site-  
21 neutral payment.

22 But if that happens, what Michael just

1       said is going to happen. And so --

2                   MEMBER ANDREWS: I would recommend, in  
3       light of this discussion and that, you know, the  
4       measures 2624, it doesn't -- it essentially says  
5       outpatient care. And outpatient care can be home  
6       care, it can be any type of rehabilitation  
7       outcome, function-related assessment.

8                   And again, I would disagree a little  
9       bit with Michael in terms of, you know, the acute  
10      rehab and long term acute care is going to go  
11      away because you can't really do away with it  
12      unless you have another provision for where that  
13      care is going to be given.

14                  As we started to push and move  
15      inpatient care to the outpatient, a lot of that  
16      extra cost moved, and needs, to the outpatient  
17      setting. So, and if you have it at home in the  
18      home setting with the right environment to  
19      support that care, then that would be fine.

20                  But again, we can't just say it's  
21      going to go away. So, again, I'm going to back  
22      and recommend that we look at 2624 as an option

1 for endorsement.

2 CO-CHAIR HANRAHAN: I think that's --  
3 I think we need to do that also, just to complete  
4 for the day. And duly noted that these measures  
5 will change in time and the circumstances.

6 MS. ANDERSON: Okay. So, we're going  
7 to look at slide 113, and the measure number is  
8 2624 and the title is functional outcome  
9 assessment.

10 It's a percentage of visits for  
11 patients age 18 and older with documentation of  
12 current functional outcome assessment using the  
13 standardized functional outcome assessment tool  
14 on the date of the encounter and documentation of  
15 a care plan based on the identified functional  
16 outcome deficiencies on the date of the  
17 identified deficiencies.

18 It's a risk adjustment outcome measure  
19 specified for ambulatory care and outpatient  
20 rehabilitation facility analysis, and it's  
21 collected through administrative claims and  
22 medical records.



1           The staff preliminary analysis is to  
2       consider for inclusion in the family and  
3       addresses a high leverage opportunity for  
4       measurement of quality of life in priority gap  
5       areas in goal-directed, person-centered care  
6       planning and implementation and optimal  
7       functioning.

8           I would note that there are a couple  
9       of exclusions. If they -- if a patient refuses  
10      to participate and if the patient is unable to  
11      complete the questionnaire, or if there's an  
12      urgent medical situation that would delay  
13      treatment and jeopardize the patient's health.

14           Go ahead.

15           MEMBER ANDREWS: I do have a question  
16      on this one. Does the measure allow for, or does  
17      it incorporate, an expectation of improvement as  
18      far as outcome measurement?

19           Or is it just an assessment?

20           MS. ANDERSON: It is an assessment.  
21      It is an assessment and a care plan based on the  
22      assessment.

1 CO-CHAIR HANRAHAN: It's a zero one.

2 Yes or no.

3 MEMBER ANDREWS: That doesn't make me  
4 feel good.

5 MS. ANDERSON: And the reason it is  
6 staff picked is because it includes that care  
7 plan element. And we've heard that from the core  
8 group before.

9 MS. SAMPSEL: Megan, this is Sarah.  
10 This is not an outcome measure. It's a process  
11 measure.

12 I just wanted to clarify that. That's  
13 where that question may be coming from. But this  
14 is a process measure.

15 MS. ANDERSON: Sorry for the typo.

16 CO-CHAIR HANRAHAN: Gwen?

17 MEMBER BUHR: So, is this saying that  
18 every time you see a patient in the office you  
19 have to document a standardized functional  
20 outcome assessment? It seems like you wouldn't  
21 have to do that every time you see somebody in  
22 the office to me if they're the same as they

1       were.

2                   MS. SAMPSEL: The measure is looking  
3       for a current functional outcome assessment, so  
4       it's not specified as every office visit.

5                   MS. ANDERSON: And I'll also note that  
6       it's in PQRS with the newest available  
7       information. It's in PQRS.

8                   CO-CHAIR HANRAHAN: Tom?

9                   MEMBER LUTZOW: Yes. This is more of  
10      a factoid. The impression is that this is  
11      agnostic with respect to what functional screen  
12      is used as long as it's an IADL focus.

13                   And right now the MDS does have that  
14      component and so does OASIS, the tool used by  
15      home health agencies. And in fact it's a measure  
16      within the five star program for plans.

17                   So, CMS actually allows us to upload  
18      that content from MDS and the content from the  
19      OASIS and load it into our case record, and it  
20      counts as our function and screen. They just  
21      need it to be done.

22                   I presume that that would also be true

1 in PQRS as long as it's current, it's done by  
2 somebody that's qualified to do it, and it  
3 doesn't need to be redone by the physician to  
4 count, as long as it's done.

5 So, is that part of the understanding  
6 here that we're talking about an agnostic across  
7 system function that, you know, MDS doesn't need  
8 to retool here and neither does OASIS? We're not  
9 asking anybody to retool anything.

10 MS. ANDERSON: Sarah, do you have any  
11 information about the data source specifications?

12 MS. SAMPSEL: Yes. I mean, this is a  
13 -- as you mentioned, it's a PQRS measure. So,  
14 this measure is a claims-based measure. It's not  
15 using OASIS and MDS. So there are G-codes that  
16 are applicable to this measure, and, you know --  
17 in order to pull documentation out of medical  
18 records.

19 MS. ANDERSON: Mady, you had  
20 something. Did you want to go to a vote? You  
21 don't want to go to a vote? Are you ready to go  
22 to a vote Mady? Okay. That's what I thought.

1                   Okay. Well, that's kind of what I  
2                   need as a staff member, is someone ready to go to  
3                   a vote and nominate for inclusion in the family.  
4                   Is that what you would like to do? Or is there  
5                   anyone who would like to vote for this measure?

6                   MEMBER ANDREWS: Is the vote to  
7                   consider this one only for a yes/no? Or is the  
8                   vote to want this one and then we go to the next  
9                   one?

10                  MS. ANDERSON: Correct. Now we are  
11                  voting on 2624 and then we will discuss another  
12                  measure and vote on that separately.

13                  Okay. So, the --

14                  MEMBER ROSS: I don't know if Mady was  
15                  joking or not, but when we first started this  
16                  conversation she said, why don't we vote the  
17                  whole block?

18                  Are the entire block helpful to people  
19                  who are dually eligible or not? So, if you are  
20                  attached to one or two, then we'd have to proceed  
21                  one by one. But -- so were you serious? Because  
22                  --

1 MEMBER CHALK: I was serious.

2 MEMBER ROSS: Okay. So maybe an  
3 alternative vote is this entire 12 list helpful  
4 right now --

5 MEMBER CHALK: In its current form.

6 MEMBER ROSS: -- in its current form  
7 to people who are dually eligible? Yes or no?

8 MS. ANDERSON: So, the inclusion of 12  
9 additional measures into the family that already  
10 includes 76.

11 I'm standing between you and dinner.

12 (Laughter.)

13 MS. ANDERSON: And I am happy to take  
14 a nomination to conduct that vote. Our Chair is  
15 not quite convinced.

16 So, we have one vote nomination on the  
17 table which is to include -- and so we have to  
18 think about the message that we are sending to  
19 CMS about the support of measures for inclusion  
20 in the family that are intended to be the best  
21 available measures for dual eligible  
22 beneficiaries.

1                   And there are 12 measures here on  
2                   functional status which have been newly endorsed.  
3                   And would -- is the workgroup intending to say  
4                   that if we include these 12 measures, we will  
5                   have fulfilled this gap and we can cross it off  
6                   the gap list, and we have now 12 additional  
7                   measures that CMS needs to continue to prioritize  
8                   and continue to contend with for the use in dual  
9                   beneficiary population.

10                  MEMBER LIND: Isn't what you mean, is  
11                  like the vote is either any or none? And so vote  
12                  yes if you want any of them considered. And then  
13                  we'd have to take them one by one.

14                  And vote no if you say no to the whole  
15                  bunch. Right? Isn't that what you're leaning?  
16                  Yes. It's more of leaning towards a no to all  
17                  vote. Not a yes to all vote.

18                  MS. ANDERSON: Okay. This is a new  
19                  option. And so we're going from looking at the  
20                  staff picks to looking at all of them together  
21                  and voting on do not include any of them in the  
22                  family. Okay.

1 CO-CHAIR HANRAHAN: Not or --

2 MS. ANDERSON: Do not include any of  
3 the 12 newly endorsed functional status measures  
4 in the family. And so we --

5 MEMBER DUNFORD: This is Jim. Would  
6 you guys -- is there a way to say, I mean, is  
7 there an existing gap that any one of these  
8 fills?

9 Or are there gaps that we've  
10 previously identified that require all of these  
11 to fill? Just from the staff point of view and  
12 your analysis of this. I wouldn't want to add 12  
13 myself in a wholesale addition without knowing a  
14 whole lot more about every one of them.

15 But, I mean, is there a gap that we  
16 should focus at?

17 MS. ANDERSON: A gap? There is, one  
18 of the six -- seven priorities gap areas in the  
19 family is optimal functioning.

20 And so two of the measures seem to  
21 have addressed functioning from the staff pick  
22 level, though all of the measures in front of you



1 address function.

2 CO-CHAIR HANRAHAN: But there's also  
3 -- there's 2286 and 2321 both do the same as the  
4 one that you selected, functional outcome  
5 assessment. Now I'm not sure what the difference  
6 is.

7 I guess, you know, I'm not sure if we  
8 vote en block to include these. Does that --  
9 what does that mean? Is it -- it is going to go  
10 to CMS and they're going to say NQF endorses all  
11 these measures, so we're going to implement them?

12 MS. ANDERSON: So these measures have  
13 been already endorsed. The recommendation from  
14 this workgroup to the Medicare and Medicaid  
15 Coordination Office would then be to -- support  
16 of all of these measures in the use -- for dual  
17 beneficiary populations.

18 And if that is the intent of the  
19 workgroup, then that is what we should vote on.  
20 Or do not support any of these measures for use  
21 in dual beneficiary populations while the optimal  
22 functioning gap still remains open.

1                   MEMBER RASK: To your question that  
2                   the 2286 is only people in an inpatient rehab  
3                   facility. So, it is the same limits as those  
4                   other ones. I thought it was -- problem is when  
5                   I looked there too, I -- what I'm sort of -- if I  
6                   was interested, as I'm thinking about it,  
7                   interesting for dual eligibles, I'm interested in  
8                   the ones that -- I'm less interested in some of  
9                   these very facility-specific ones.

10                   I feel like they don't necessarily  
11                   need to jump in and be used. But the 2624 that  
12                   at least is more of an outpatient, more generic,  
13                   that seems like a reasonable -- giving us  
14                   something in the functional assessment area that  
15                   might be applicable to a broader group of dual  
16                   eligibles while these other very specific ones,  
17                   save them for another day to see if we really  
18                   have a gap in that particular area that needs to  
19                   be filled.

20                   MEMBER CHALK: And by the way, in my  
21                   slide deck that I have here that was sent, there  
22                   were two 2686 measures. One says inpatient rehab

1 facility. I can show it to you. It's on my  
2 slide deck. And the other one says it's been  
3 specified for all kinds of other settings. So,  
4 which one is it?

5 MS. SAMPSEL: So, this is Sarah again.  
6 2286, 2287, 2321, they are all specified at the  
7 level of the inpatient rehabilitation facility.

8 MEMBER RASK: So, I would like to make  
9 a motion that we consider individually 2624.

10 MS. ANDERSON: Okay. So I think we  
11 have the slide ready to vote on 2624, and this is  
12 the inclusion of a single measure into the  
13 family, and it is the functional outcome  
14 assessment.

15 Again, a reminder, this is a  
16 standardized functional outcome assessment tool  
17 and documentation of a care plan based on the  
18 deficiencies, and it is a risk adjusted process  
19 measure for ambulatory care and outpatient  
20 settings, and it is in PQRS.

21 We've had a lot of discussion since we  
22 went over that so point your clickers at Janine

1 and she will let you know what's up and down.

2 MS. AMIRAULT: Okay, so for measure  
3 2624 on being added to the family of measures,  
4 one being yes and two being no.

5 (Voting.)

6 MS. AMIRAULT: Okay. We have ten yes  
7 and six no, and based on the percentage of 63,  
8 this is in consensus to be added to the family.

9 MS. ANDERSON: Thank you. So we have  
10 added 2624, functional outcome assessment, to the  
11 family of measures for dual beneficiaries.

12 And we will move on if we have another  
13 nomination for inclusion to the family for the  
14 staff pick of 2631. I heard that before. Does  
15 that stand?

16 Alice, do you still want to nominate  
17 2631 for inclusion in the family? The staff  
18 pick?

19 MEMBER LIND: I don't want to nominate  
20 any of these other measures.

21 MS. ANDERSON: Not the staff pick  
22 though? No? Okay. I misunderstood.

1           Would anyone else like to nominate any  
2 of the other measures for inclusion into the  
3 family of measures?

4           (No response.)

5           MS. ANDERSON: Okay. I am  
6 understanding that as -- then that the gap  
7 continues to persist in the family of measures of  
8 optimal functioning. While this measure is a  
9 start, and we will continue to observe the  
10 development and implementation of the remaining  
11 measures, and as that information becomes  
12 available, bring it back to this workgroup for  
13 consideration and recommendation. Okay.

14           So, it is about time for public  
15 comment. Unless there are any other thoughts?  
16 Okay.

17           Operator, can you please open it up  
18 for public comment? And other than the room, if  
19 there's any public comment, and Janine, whether  
20 or not there's any comment in the chat.

21           OPERATOR: At this time, if you would  
22 like to make a comment, please press star then

1 the number one.

2 (No response)

3 OPERATOR: And at this time there are  
4 no public comments from the phone line.

5 MS. ANDERSON: Thank you very much.  
6 I'm going to turn it over to Janine to give us a  
7 little bit of a reminder about our plans for this  
8 evening.

9 MS. AMIRAULT: Hi everyone. So yes,  
10 just as a reminder, we're going to be doing  
11 dinner at Georgia Brown's at 6:30 tonight, so I  
12 guess -- it's close by. And we can send the  
13 address if anyone doesn't have it.

14 MS. ANDERSON: If you walk out the  
15 main lobby of this building, and you go right, it  
16 is across the street. And if you are at the  
17 hotel, you also go right, and then you go right  
18 again. It's around the corner.

19 If these -- for those workgroup  
20 members, please keep your receipts. This will be  
21 individualized receipts and you'll submit them to  
22 NQF with your other reimbursement information.

1                   And we look forward to seeing you this  
2 evening for those of you who can make it. And  
3 for those -- for all of us, tomorrow morning  
4 breakfast starts at 8:00 a.m.

5                   It's continental breakfast similar to  
6 today. We have a full day and the meeting starts  
7 at 8:30, in which we'll recap some of what we  
8 talked about today. Bring you perhaps two  
9 additional measures for consideration and talk  
10 about prioritization, then we'll hear about HCBS  
11 and the ongoing NQF effort to explore measures  
12 for HCBS. And we'll really delve into community  
13 integration and connectivity resources midday.

14                  So, we thank you very much for your  
15 participation and attention today. And you get  
16 out 15 minutes early even though we're behind by  
17 45 minutes today. So, congratulations. Good  
18 job.

19                  (Whereupon, the above-entitled matter  
20 went off the record at 4:44 p.m.)  
21  
22

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In the matter of: Measure Applications Partnership  
Dual Eligible Beneficiaries W/G

Before: NQF

Date: 04-19-16

Place: Washington, DC

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